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The social context of service provision for people with learning disabilities : continuity and change in the professional task

The Social Context of Service Provision for People with Learning Disabilities: Continuity and Change in the Professional Task

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This research examines the history of services for people with learning disabilities between the middle of the nineteenth century and the end of the twentieth century. A macro approach has been used to identify social, political and economic factors that have influenced the development of policy and specialised provision across Great Britain. A case study of Stoke Park Hospital, Bristol has been used to examine the micropolitics of service delivery at a local level. Analysis of data derived from documentary sources has identified key factors that led the rapid expansion of the site between 1909 and 1916. Interviews with nurses and care staff have been used to create a record of their impressions of the learning disability services in 1996. Documentaries and newspaper reports have also been used to provide details of Stoke Park between 1960 –1997.

The concept of continuity and change has been used to compare and contrast developments from different historical periods. Analysis has been focussed on four major themes that appear in each chapter. These themes are the "Concepts, Definitions, and Characteristics That Have Been Used to Identify People with Learning Disabilities", "Streaming and Classification", "The Role and Function of Services", and "Resources and Responsibilities".

Material from the literature review, and data from documentary sources and interviews, have been used to explore the changing dynamic between institutional and community care. In the context of this research "community care" has been used to denote care provided by families and other informal carers, a way of augmenting and extending institutional care, and the care that has been provided to replace long stay hospitals. Analysis has also been focussed on the relationship between social policy and service provision, and their combined impact on the role of professionals and carers that work with people with learning disabilities.

I would like to thank my supervisor David Gladstone, and my colleagues in the Faculty of Health and Social Care at the University of the West of England, for their support, guidance and encouragement.

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original except where indicated by special reference in the text and no part of the dissertation has been submitted for any other degree.

Any views expressed in the dissertation are those of the author and in no way represent those of the University of Bristol.

This dissertation has not been presented to any other University for examination either in the United Kingdom or overseas.

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Abbreviations

BBC	British Broadcasting Corporation
BMA	British Medical Association
BOC	Board of Control
BRO	Bristol Records Office
CRIS	Commissioners of Reformatories and Industrial Schools
DHSS	Department of Health and Social Security
DOH	Department of Health
IPP	Individual Programme Plan
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
NAMH	National Association for Mental Health
NHS	National Health Service
NIPRCC	National Institutions for People Requiring Care and Control
Roy. Com. Feeb.	Royal Commission on the Care and Control of the Feeble-Minded (Cd. 4215-4221, 1908)
OT	Occupational Therapy
PRO	Public Records Office

Chapter 1

National Developments 1845 - 1908

Introduction

The aim of this thesis is to examine the development of services for people with learning disabilities from a historical perspective. Analysis will explore the effects of continuity and change on the delivery of services and examine their impact on the development of professional roles. Four themes divide the material in each chapter. The themes provide a consistent framework for the analysis of service provision from different historical periods. The first theme has combined material relating to the concepts, characteristics and definitions that have been used to identify people with learning disabilities. The second theme examines different schemes involving streaming or classification. The third theme has combined material pertaining to the role and function of different services. The fourth theme has incorporated material, which examines the deployment of resources and the delegation of responsibility within services.

This chapter will look at the services that were available prior to the 1913 Mental Deficiency Act and the different ways in which users, or potential users of those services, have been characterised. Identification and classification have been treated as separate processes within the chapter with a separate section dedicated to each. Identification is the process that has allowed agencies providing different services to distinguish between those individuals in the population that required specialised services, and those who did not. Material in this section looks at the concepts, characteristics and definitions that have been used to describe people with learning disabilities. Classification and streaming has facilitated the sub-division of a defined population into smaller groups constituted from people that were regarded as having the same, or similar, characteristics and needs. The schemes of categorisation that have been used to sub-divide the population that acquired the learning disabilities label are the basis of the second section in this chapter. Both identification and classification have involved the development of explicit and implicit criteria.

The explicit criteria that have been mentioned in this chapter include the diagnosis of conditions associated with mental deficiency, and the use of norm-related intelligence testing as a criterion for indicating mental deficiency. This chapter will also refer to the implicit criteria associated with different labels and stereotypes. The combination of these processes has exerted a powerful influence on the attitudes and values that have been attached to people with learning disabilities. Stereotypes, labels and stigma have also surrounded the services that have been provided for people with learning disabilities, and the staff that work in them. These processes have been particularly potent where they have contributed to the social construction of "difference" i.e. the perception of difference that separates groups that are described as deviant from the rest of population. Although attitudes, values or beliefs may be concealed or disguised they are manifested in the social interactions between people with disabilities and people without them. Material on the role and function of services has made reference to the stigma attached to welfare, unemployment, and residence in a workhouse to show the origins of some of the negative imagery that has adhered to the recipients of services. Material that appears in the final section of this chapter has been used to establish links between the prevalence of attitudes and beliefs attached to specific groups and their impact on the deployment of resources. Widely held beliefs about the nature and origins of learning disabilities have been an integral part of the decision making process that has determined the quality and availability of support in the community, residential care, education, training and employment for people with learning disabilities.

Within the context of a historical study it has been possible to look at ways in which the past has configured the present. Paul Rock (1973, p.156) has written, "much contemporary deviance is a fossilized residue from the past." It is his contention that people and contemporary services are constrained and oriented by the past. A lot of developments in the services that have been described in the first chapter have contributed to a stream of imagery and mythology that runs into the present. Similarly many of the concepts that were established as indicators of "difference" still contribute toward the social

construction of learning disabilities in the present day. Although services have been moving away from hospital provision since the 1950s the strength of the association between learning disabilities, segregation, colonies and hospitals has meant that the links have persisted even though a majority of people with learning disabilities live (and always have lived) in the community.

Concepts, Definitions, and Characteristics That Have Been Used to Identify People with Learning Disabilities

Writing about the history of madness and society Scull (1979,1993) has described the period between the mid-eighteenth and mid-nineteenth centuries as a time when the typical response to the deranged underwent dramatic changes. One significant aspect of these changes was the capacity of the state, and a variety of professional and semi-professional "helping occupations," to differentiate between different sorts of deviance. At the beginning of the period people designated insane, idiots or imbeciles were part of a large, amorphous group that included the morally disreputable, the poor, minor criminals and the physically handicapped. Although a minority of people received services via prisons, workhouses or a limited number of places in private and charitable asylums, the majority of the insane were to be found living, or being cared for, in the community. Families provided care for family members, or they were paid to provide food and lodgings for non-related individuals that were "boarded out". When families were unable to provide care the Elizabethan Poor Laws had made it the responsibility of the parishes in England and Wales to provide for their indigent poor. Relieving Officers were hired to dispense small cash payments, food, clothing and medical care using money that was derived from local taxes.

Between the late eighteenth century, and through the nineteenth century, the situation changed so that greater emphasis was placed on providing institutional solutions and professional intervention to contain or resolve the problems associated with different types of deviance. Creating the apparatus that could be presented as a credible solution, or means of containing these problems, necessitated greater involvement from the state as well as input from

a variety of professionals. Scull (1993, p.10) has stated that from the late eighteenth century onwards the development of institutional solutions was assisted by the emergence of a "highly rationalized, centrally administered and directed" apparatus that was designed to monitor and control the deviant population. The solutions it provided were characterised by the development of specialised institutions that segregated residents from the rest of the community and placed them under the authority of a succession of lay-carers and professionals. Scull's writing has focused on the history of madness, and the emergence of the psychiatric profession, but he has maintained that the differentiation of the insane is a particular example of more pervasive changes in the social organisation of deviance. The history of services for people with learning disabilities follows a similar, but not identical path. It follows the general pattern of change in the social organisation of deviance but it remains distinct and different from the history of services for the insane. Although it has involved the delimitation of a population that were labelled as mentally deficient rather than insane, and the creation of a specialised service (including the provision of institutional care), there are significant differences. The emergence of these differences reflects the divergence of services designed to care from those designed to cure, and the evolution of different roles adopted by the professionals, semi-professionals and lay-carers in the delivery of services.

In his discussion of learning disability and the Poor Law, Wright (2000, p.732) asserts that the labels applied to the "insane", "idiots" and "imbeciles" were used selectively to save money. He maintains that local Poor Law and lunacy officials colluded to keep harmless "idiots and imbeciles" in the Poor Law Union workhouses rather than accommodating them in more expensive state asylums. This appears to contradict the medico-legal definition of insanity from the 1845 Asylums and Lunatics Act that made reference to idiots and imbeciles, making both groups eligible for detention. Wright (2000, p.736) states that the lunacy legislation, and the asylum system that it underpinned, "dealt explicitly and unambiguously" with the learning disabled so that idiots and lunatics were subject to the same legal authority during the Victorian era. In spite of a legal framework that amalgamated all of these groups the services that they received were different. While those people with learning disabilities who were seen as

dangerous were more likely to be sent to the county asylum, those perceived as harmless, or "incurable," were more often found in the mixed population of the Poor Law Union Workhouse. Thus a small proportion of those deemed to be insane included people that may have been recognised as idiots or imbeciles, but their presence in an asylum was due to an additional label that identified them as dangerous or threatening. Those people that were deemed to be harmless may have acquired the label of idiot or imbecile, but the low level of disruptive behaviour associated with this group, and their imperviousness to the benefits that were attributed to a curative regime, meant that they remained in the workhouses where they were unlikely to receive a specialised service.

Wright (2000, p.738) has estimated that the asylum population in 1850 was 15,000 persons. About 1 000 people with learning disabilities were resident in county asylums. By contrast the returns from the Lunacy Commissioners suggested that there were 10 000 insane persons in workhouses across the country, most of whom were "idiots" or "imbeciles". Despite the strong association between the Victorian era and the development of institutional provision the distribution of people with learning disabilities between asylums, workhouses and families has indicated that asylums had not displaced the family and community as the locus of care (Bartlett and Wright, 1999). Different interpretations of the labels "insane", "idiot" and "imbecile", the distribution of the population between various institutions, and a lack of reliable evidence about the number of people in the community, have made it difficult to define or quantify the population with learning disabilities. Evidence from the late eighteenth and early nineteenth century has provided information about various attempts to calculate the number of people with a learning disability. During 1881 a return of idiots in public institutions totaled 29,452. In the following year Daniel Hack Tuke stated that the figure was unreliable because it omitted a significant number of people that had not been recognised by the public authorities (figures cited from Jones 1972, p.182). While Scull (1993) described residents in the early asylums as an "amorphous" group, Jones (1972, p.184) has attributed anomalies in the data about people with learning disabilities to the "submerged nature of the whole problem". Figures that were derived from

the number of people in public institutions would not reveal people who lived on their own, with their families, or other families. Data collected from public institutions would also exclude those people who had been accommodated in private facilities. This may have been a notable omission because Scull (1993) has described private madhouses as a well-established phenomenon by the late eighteenth century.

At the beginning of the nineteenth century the terms "cretin", "idiot" and "imbecile" were used more or less interchangeably. As the century progressed evidence established the link between "cretinism" and thyroid deficiency. Sutherland (1984, p.14) has cited Dr John Haydon Down's description of Down's Syndrome in 1866, and the publication of W.W. Ireland's "On Idiocy and Imbecility" during 1877, as indicators of an expanding body of medical knowledge pertaining to mental deficiency. Rose (1985, p.54) has stated that:

> By the mid-nineteenth century, the idea that mental pathology had a physiological or organic basis, an origin in a neuropathic constitution, intimately linked to the make-up of the brain and transmissible across generations was well established.

Developments in medical psychology, the emergence of neurophysiology as a medical specialism, Gall and Spurzheim's phrenology (1810, 1835) and the work of Combe (1831) and Carpenter (1842) led to a "conception of the constitution which could be normal or abnormal" (Rose 1985, p.56). The accumulation of this knowledge provided a scientific basis for categorising people with mental illnesses and learning disabilities and created records which catalogued the characteristics that identified them as being different from the rest of the population. Connections that were made between various deficiencies, variations, malformations, and their potential to reproduce in succeeding generations indicated that any services that were provided by the state, voluntary organisations or the family would involve a long-term commitment. The data that was collected suggested that if the condition could not be contained, or eradicated, then care and treatment would be required for their offspring.

The submerged nature of the problems associated with learning disabilities had resulted from a combination of links that had been made between different factors. Isolating people with learning disabilities, to obtain information about them, was complicated because they were often subsumed in larger groups. The members of different groups were connected by policy makers, administrators and professionals who thought that a common thread of anti-social behaviour linked them all together. They were distinguishable from the rest of society through an amalgam of ideas that combined poverty, heredity, and social deviancy. Together they posed a threat to social order that necessitated guidance and management. One solution to the array of problems they presented was expressed in terms of the need to provide effective “care and control”. Collectively they were referred to as the "social problem group", a term that was used explicitly in the Wood Report (Interdepartmental Committee on Mental Deficiency 1929, p.80):

> Let us assume that we could segregate as a community all the families in this country containing mental defectives of the primary amentia type. We would find that we had collected among them a most interesting social group. It would include, as everyone who has extensive practical experience of social service would readily admit, a much larger proportion of insane person, epileptics, paupers, criminals (especially recidivists), unemployables, habitual slum dwellers, prostitutes, inebriates and other social inefficients than would a group of families not containing mental defectives. The overwhelming majority of the families thus collected will belong to the community which we propose term to the "social problem" or "subnormal group".

The report went on to emphasise that the problem was not limited to isolated individuals, or a few scattered groups, but a growing section of the community that could continue to expand until it precipitated a "racial disaster".

Pick (1989, p.184) has identified a shared vision of society emerging in the last decades of the nineteenth century that laid foundations for the type of view expressed in the Wood Report. He described a strand of pessimism, running across otherwise eclectic political writing, reflecting doubts about the viability of the “imperial mission”. Society was envisaged as an organic process under threat from the combined impact of illness, pathology and degeneration. Pick

has asserted that the promulgation of these views among intellectuals, scientists and politicians accelerated the growth of fin de siecle pessimism. An intellectual climate was cultivated whereby it was credible to present the reproductive capacity of the physically, mentally and morally unfit, and the expansion of the urban poor as social issues that jeopardised race and nation. Measures that purported to identify, avert or contain their disintegrative effects gained currency. The concepts of a "residuum" and "Englishness" were used to define a double movement that Pick (1989, p.215) has described as inclusion and exclusion, "ideological assimilation and expulsion". Inclusion, exclusion, assimilation and expulsion, were ideas that were used to establish boundaries around social groups and to indicate where cross-class allegiances could be used to combat both internal and external "threats".

Streaming and Classification

Wright's analysis (2000, p.736) of the allocation of places in Poor Law Union workhouses and county asylums shows that a rudimentary streaming system was operational. Decisions regarding institutionalisation were not based on any medico-legal distinction between idiots and lunatics but on an appraisal of the "dangerousness" or "curability" of the person in question. A decision about the perceived dangerousness or curability of an individual was required because the availability of asylum beds was limited. After the 1845 Act emphasis was put on managing the dangerous and treating the curable in asylums, while provision for those individuals that were perceived as harmless and incurable was restricted to cheaper places in workhouses. This section will examine other forms of streaming and early attempts to classify people with learning disabilities. It will continue with an examination of the treatment of "idiots" in the educational system and the beginning of "special" education. It will then go on to look at employment and how an individual's availability for work was used to separate people that were potentially employable from others that were labelled as unfit or disabled. Finally this section will examine the use of intelligence testing to gauge an individual's potential. In schools appraisal of an individual's intelligence was used to make explicit decisions about that person's suitability for education. Appraisal of intelligence was also used implicitly to make

judgements about a person's ability to live independently, their capacity to maintain themselves by generating a private income, as well as their capacity to add to (or detract from) the nation's wealth.

Scull (1993) has described how physicians secured control over psychiatric services by shutting out any competitors that proffered alternative forms of treatment for insanity. Their control over the development of learning disability services was less exclusive. With mental illness the process of diagnosis, treatment, and the prospect of curing the patient provided physicians with weapons to use against the "disease" and a source of solace for the sufferer. A learning disability was more difficult to diagnose because of the range of abilities and impairments that had been subsumed in the term "mental deficiency" and its precursors. In addition physicians could not elevate their status above other providers of services by claiming to possess exclusive knowledge or skills that would cure the condition. Although their knowledge and expertise was called on to recognize and label different grades of "defective" there was no direct link to the prescription of a specific cure or course of treatment. While some aspects of mental deficiency could be ameliorated through education and training neither was subject to exclusive control by the medical profession.

Education

Sutherland (1984, p.15) has drawn attention to the work of Dr G.E. Shuttleworth and the Egerton Commission at the end of the nineteenth century. Shuttleworth was a medical psychologist, Superintendent at the Royal Albert Asylum, and a medical witness to the Commission. He also published a textbook titled "Mentally Deficient Children" in 1900. His work is of interest because it embraces the concept of streaming and classification as well as questions of care and treatment. It is also indicative of the prevalence of medical ideas pertaining to learning disabilities. Potts (1983, p.181) has argued that medical ideas were widespread in education:

> Doctors defined and classified disabilities; their categories became the non-educational basis for educational legislation and provision; they assessed the children referred for separate schooling; they

inspected the special schools; they frequently dictated the curriculum, time-table and teaching methods, and they drafted educational policy documents as School Medical Officers within the Board of Education.

Shuttleworth produced a classification scheme that "streamed" children according to their capacity to benefit from school. Streaming divided the "idiot" class into four separate groups. Groups comprised of those capable of learning to read and write, those capable of benefiting to a minor degree from school instruction and discipline, and the "ineducable" class. The fourth group comprised those individuals that were labelled as "weak minded" or "backward" children. Unlike any of the previous aetiological classifications allocation of individuals to any of these groups was based on an estimation of probable benefits. The categories lacked the rigour of a full medical examination. Instead they relied on prediction or a period of trial and error in the classroom. The creation of four discrete categories denoted a structured approach to the distribution of resources between groups. Instead of being described as a homogenous body of mentally deficient children they were subdivided according to their perceived abilities and their capacity for improvement. This facilitated discussions about the advantages and disadvantages of providing (or withholding) education for each of the groups.

As Wright's observations on the Poor Laws have suggested streaming was indicative of concern over the allocation of limited resources. Within the education system it created an opportunity to distinguish between children that would benefit from remaining in elementary schools, or other forms of non-specialised provision, and those who would not. By moving the boundaries which separated the number of children who required specialised provision from those who did not the potential cost of services could be raised or depressed. Such a scheme made it possible to avoid costs based on the aggregated needs of a homogenous category of "idiots" by separating smaller groups of "ineducable", "weak minded" or "backward" children from those capable of deriving benefit from the existing classes. If children with milder disabilities were to be retained within the elementary school system their impact on educational standards, and the performance of the rest of the class, also

had to be considered. The educational achievement of children with disabilities isolated them from other children of a similar age. Their inability to negotiate the hurdle presented by examinations had made them congregate around Standard 1, with the seven year olds, or occasionally in larger schools, a separate Standard "0". At the same time the implementation of a “payment by results” system was exerting a strong influence over teachers' responses to students that were regarded as having a deleterious effect on exam results and levels of achievement. Payment by results had been introduced in 1862. The impetus to remove children that were difficult to teach, or hard to control, and put them in “special” schools was strengthened by the introduction of compulsory education in 1880.

Sutherland (1984, p.19) has cited Major-General F.J. Moberley as a notable advocate for special educational provision. He was chairman of the board of the London School Board's sub-committee on the blind and deaf. His campaign to establish a special school began in 1890. The first school was opened in 1892. By 1897 there were twenty-seven schools in London and the school boards in Leicester, Nottingham, Birmingham, Bradford, Brighton, Bristol, and Plymouth had started to make separate provision so that a total of 13,000 children were attending special schools and classes. Jones (1972, p.187) has cited an example from the education authorities in Birmingham. During 1894 Mrs Hume Pinsent, who served on the Birmingham Special Schools sub-committee, visited classes in all of the 56 Birmingham schools where special classes had been established. Early contact with the schools had made her aware that some headmasters and headmistresses were confused about the purpose of the special class and the pupils for whom it was intended. As a result of her visits Birmingham appointed Dr Caroline O'Conner as inspector and within a few years the number of children receiving their education in special classes had risen from 100 to 600. This would suggest that once special classes or schools were established they underwent a period of rapid expansion so that they could accommodate children who had not been identified in the past.

The development of special schools effectively streamed children with learning disabilities into three groups. Those who could remain within the education system available to children without disabilities, another group who required education in special schools or classes, and a third group who were regarded as incapable of benefiting from any form of education. The role and function of the schools was ambiguous. Used in conjunction with a scheme of classification they provided facilities for those children who were deemed to be educable. While children with mild learning disabilities who did not warrant a place in a special school were to be left to their own devices there were no plans for children with severe disabilities. The schools did not have a clearly defined role as part of a comprehensive strategy for producing services for people with learning disabilities. The attention that was given to "idiots" in the education system suggests that they were singled out because they interrupted the flow of pupils through elementary schools and caused disruption in the classroom, not because they were the most deserving, neglected or impoverished. The real beneficiaries of these developments were likely to be the teachers and pupils who remained within the elementary system because teaching styles and learning could be refined once children with learning disabilities had been removed from the class.

The emphasis on educational attainment and performance in the classroom offered an alternative method of identifying feeble-minded children that could be used in conjunction with medical diagnosis. Prediction or periods of trial and error in the classroom were more subjective methods of identification. Teachers working with feeble-minded children in classrooms were more likely to make comparisons between children in the same class or with children of the same age. The stereotypes, labels and stigma attached to any person with a disability were also likely to exert some influence on judgements that were made regarding a child's behaviour, personality or abilities. Educational assessment at this level increased the likelihood that criteria used for identification or classification would contain implicit as well as explicit components. The formation of schemes involving medical diagnosis and assessment by a teacher signified the importance of professional judgement,

and the discourse between different professions, in making decisions about the appropriateness of specialised services.

Work

Work was another boundary that separated people labelled as learning disabled from the rest of the population, and divided them from one another. The capacity to generate an income became a useful determinant in appraising the number of people who were likely to be dependent on the state, or voluntary agencies, and those capable of an independent life. While availability for work became a useful variable in determining the quantity and quality of provision that was required, the number of jobs available for people with motor, sensory or mental impairments was diminishing. Ryan and Thomas (1980, p.101) have described how industrialisation contributed to the construction of a disabled category. The introduction of more factory work excluded a proportion of disabled people from the production process. Factory work synchronised the speed of individual workers with one another and the machinery they were using. Those people who could not maintain the required pace were likely to be regarded as unprofitable or unsuitable employees. While mechanisation made the factory work force appear more homogenous it created an environment in which individual differences, such as the capacity to adapt to different jobs, machinery and people were more noticeable.

Topliss (1979, p.11) has described how urbanisation inhibited the integration of people with disabilities:

> By the 1890's the population of Britain was increasingly urban and the employment of the majority was industrial, rather than rural. The blind and the deaf growing up in slowly changing scattered rural communities had more easily been absorbed into the work and life of those societies without the need for special provision. Deafness, while working alone at agricultural tasks that all children learned by observation with little formal schooling, did not limit the capacity for employment too severely. Blindness was less of a hazard in uncongested familiar rural surroundings, and routine tasks involving repetitive tactile skills could be learned and practiced by many of the blind without special training. The environment of an industrial society was however different.

The transition from a rural to an urban society eroded the status of disabled people and reduced the likelihood of employment. The scale of these social changes had an impact on everyone with a disability and not just people with learning disabilities. Working practices, the organisation of the workplace and problems associated with an urban environment contributed to the social isolation of disabled people. Morris (1969, p.9) has stated that the development of a market economy in the nineteenth century relegated disabled people to the bottom of the labour market. Social change and the speed of life in industrial, urban areas made integration difficult. Disabled people became detached from the institutions which delineated everyday life such as the workplace, and the social life that developed in towns and cities. They were excluded from the social and cultural events that were available to the rest of the population because of the restrictions imposed on them by a changing environment and their economic circumstances. The relationship between disabled people and the population without disabilities became problematic. The characteristics which made them different, their detachment or resistance to social changes, and their relation to labour cultivated the belief that disabled people were a social as well as an educational problem.

Intelligence Testing

Intelligence testing provided a means of identifying and classifying people with learning disabilities that had scientific credibility without the connotations of a medical diagnosis. Tests of intelligence were not reliant on medical criteria or prejudices reflected in the personal opinions of teachers or parents. Unlike a record of employment, which would be influenced by the type of work undertaken and the availability of jobs, intelligence testing was seen as a reliable indicator of an individual's potential. The tests were seen as a way of judging an individual's capacity to learn as well as their actual achievements. They were thought to have a predictive value as well as providing an immediate measurement of intellectual ability. The deployment of IQ tests in services, which covered large sectors of the population, like the education services, facilitated the collection of data pertaining to large samples. The compilation of data gathered through these services also encouraged a range of professionals

to interpret statistics and rationalise their judgements by appealing to the concept of a norm.

Rose (1985, p.65) has described how the measurement of intelligence encouraged an alliance between statistical procedures and schemes of classification and distribution. The concept of a norm, derived from mathematical calculations, enabled the characteristics of a population to be measured by their distance from a central point:

> Norm was that central point which, in virtue of the probability of deviations from it and their magnitude, allowed the statistical conceptualisation of populations in terms of the regular distribution of variations.

When these tests were used in the context of intelligence they provided a formal dividing line which separated those who had an IQ score within the normal range from those who were categorised as subnormal.

Drawing a dividing line based on a hypothetical norm performed many different functions. It linked the development of individual psychology with statistics and social functioning. By making this connection it was moving away from any model relating to the normativity of psychic functioning towards a practice which Rose (1985, p.123) has described as administrative rather than clinical. The acceptance of tests, which purported to measure intellectual potential, exerted a powerful influence on developments within the education system. Ryan (1980, p.110) has described how the use of intelligence testing lent credence to the development of classification schemes that used the concepts of educability and non-educability:

> This shift reflected new psychological notions about mental competence arising from the imposition in the 1870s of universal education and subsequent invention in 1908 of IQ tests. The assumptions of these tests, namely that the IQ was a measure of a fixed potential with which each individual was born and which determined his or her educability, meant that mental defectives were classed as having very little potential and thus as being hardly educable.

Schemes of classification derived from a measurement of innate potential fostered a concomitant set of beliefs concerning the reasons for success or failure within the education system. Failure was more likely to be seen as the consequence of limited ability or potential rather than a consequence of adverse environmental conditions or inappropriate teaching methods. IQ measurement also meant that it was possible to calculate whether an individual was likely to be able to gain any benefits from receiving an education. Ryan (1980, p.110) has stated:

> According to such definitions, mental defectives could not be made more intelligent and so belief in their capacity to learn anything tended to be very small and thus the importance of education in their lives - particularly of the more severely defective - was minimised.

The promulgation of beliefs concerning the limited benefit that mental defectives could derive from education, coupled with the development and deployment of scientific tests that legitimised their separation or exclusion from the education system, also provided a rationale for limiting resources. Unless education was capable of transforming mental defectives, or at least ameliorating their condition, the resources that were allocated to them could be used more effectively in other services or redirected to serve the nation's wider interests.

Although IQ tests purported to measure intelligence the introduction of tests had repercussions that extended beyond their role in the educational system. Measurement of a person's intellectual powers were also construed as being indicative of other aspects of that person's character and their value to the rest of society. Rose (1985, p.92) has stated:

> From Galton onwards, variations in human intellectual powers were necessarily linked with variations in industriousness, moral and civic worth and so forth. An individual's intellect was an index of the quantity of heritable vital energy possessed, of the general quality of stock.

Measurements of intelligence, used in conjunction with other factors, became an important point of reference for establishing differences between individuals with learning disabilities as well as a way of separating them from the rest of the

population. Comparison or measurement of the differences between the two groups accentuated the negative values, attributes or deficits which were associated with "idiocy" while simultaneously reinforcing the positive attributes of the population that were characterised as normal. Social relations between the two groups were also described in terms which reflected the extent to which this minority group depended on the benevolence of the majority, and the threats they posed to the people they relied on. They were surrounded by negative imagery. Mental defectives were associated with social problems, which were inimical to social stability and order. At the same time they were represented as people who placed demands and onerous responsibilities on the family, philanthropic institutions, and medical science. Dependency and difference were emphasised through the way they were depicted as a burden on those who generated wealth, or a barrier to the implementation of an efficient and effective education system.

The Role and Function of Services

References to people with learning disabilities as a social problem, a long-term drain on national resources or a racial disaster depicted them in a very negative manner. This was a departure from a more optimistic outlook that had been evident at the beginning of the century. During 1801 Doctor Itard[1] had published "L'Education du Sauvage d'Aveyron" describing the beneficial effects of socialisation on a "wild" boy. Itard's work, and that of his contemporary Seguin, established a belief in the value of providing education and training for people with learning disabilities. This led to the foundation of the first institute for the education and training of mental defectives in Paris during 1839. A similar conviction regarding the value of education was evident at the opening

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[1] Itard's instigation of moral treatment for Victor (the "wild" boy) had been founded on the belief that he was not an "idiot". Unlike Itard, Edouard Seguin believed that Victor was an "idiot", but he maintained that idiots could be educated. Although he believed that "idiots" were incurable, they were not ineducable. Education had a moral function combined with a philosophical basis, and a physiological method that entailed stimulation of the muscles and senses to revive the higher thought processes. Seguin opened the first school for "idiots" and was the author of *Treatment Moral, Hygiene, et Education des Idiots* (Paris, 1846). See N. Rose *The Psychological Complex* (London,1985) 36-38, and M. Thomson *The Problem of Mental Deficiency Eugenics, Democracy and Social Policy in Britain c.1870-1959* (Oxford, 1998), 11, 122.

of the asylum at Park House, Highgate, twenty-six years later. The brochure for the asylum proclaimed that it was now a fact that "idiocy" was susceptible to improvement through education:

> We have laboured under the appalling conviction that idiocy is without remedy, and therefore we have left it without help. It may now be pronounced, not as an opinion, but as a fact, a delightful fact, that the idiot may be educated.
> (cited in Jones 1972, p.183)

Although small private asylums offered the prospect of education to a limited number of residents most people with learning disabilities were either being cared for by their families at home or submerged in the mixed population of workhouses. Only 3% of those people included in the return of 1881 were receiving specialised services of any kind. Both Wright (2000, p.743) and Jones (1972, p.182) have maintained that the evolution of the Poor Laws and the Lunacy Acts in the second half of the nineteenth century delayed the implementation of separate provision for the learning disabled until after the Mental Deficiency Act of 1913. The separation of the curable and violent left the majority of chronic, non-violent “idiots” and “imbeciles” outside of the county asylum system. In the workhouses there were very few “special” arrangements made for them. Under these conditions the residents were unlikely to convince doctors, commissioners or administrators of their capacity to benefit from education and training.

Until the building of the Darenth Training Schools specialised provision was not seen as an area that warranted large-scale investment from public funds. The Schools were established by the Metropolitan Asylums Board during the 1870s. Wright (2000, p.732) has pointed out that the Board’s action created a divide between provision in the Metropolis and the conditions that prevailed in the provinces. When strategic planning at a national level, with investment from public funds on a larger scale, was introduced in the early part of the twentieth century there had been a significant change in attitudes towards people with learning disabilities. The development of services was not a benign response to suggestions that idiots could be educated, or even a concerted attempt to improve the quality of life and opportunities for people with learning disabilities.

The services that evolved were mechanisms that had been designed to isolate, control, and contain a group that had been labelled as a social problem.

Scull (1993, p.29) has asserted that institutional care emerged as part of the reorganisation of society along market principles. The rise of capitalism and the movement towards commercialised production extending across national and international markets had transformed Britain by the end of the eighteenth century to the extent that Polanyi (1957) has described the running of society as an adjunct to the market. The rest of this section will explore how schools and the workhouse were used to enhance the nation's productivity. The concept of educability, and the provision of special education encouraged further sifting and separation of people with learning disabilities. The acquisition of the labels "improvable" or "non-improvable" were used to designate a person's usefulness. Similarly workhouses were used to establish the principle of "less eligibility" so that those people that had the potential to perform useful work were discouraged from seeking assistance. Viewed in the context of national prestige, trade, and industry, the roles performed by these services were defined by a desire to remove any impediments to the production of wealth.

By 1905 there was evidence of more concerted pressure to develop comprehensive services that would stream children and bring them together in services providing educational and medical "supervision". Questioning of Sir Edward Fry[2] during the Royal Commission on the Care and Control of the Feeble Minded (1905) contained the following exchange:

> Would you consider that special classes were the beginning of the education, and necessary therefore to any system for dealing with these cases? - I am not sure that I apprehend your question.
>
> Under the Act there are special classes, generally allied with boarding out? - They may be constituted, yes.

[2] The Right Honourable Sir Edward Fry was described as Chairman of the Quarter Sessions, Somersetshire, formerly Lord Justice of Appeal (*Roy. Com. Feeb., I, p.IX*). He was involved in a proposal that the County Council of Somerset should establish a small school for "imbecile pauper children"(*Roy. Com. Feeb., I, p.311*).

> In that way children are brought together at an early age, and they are practically under educational and medical supervision, so that later on it will be quite clearly ascertained what line should be taken with them, whether they should gravitate downwards, more like idiots or imbeciles? - I think that would be a very useful mode of dividing into the two classes I spoke of improvable or non-improvable. I suppose they are the two classes you refer to. [3]

Segregation "at an early age" was presented as advantageous because it established a foundation for the development of two separate categories; the improvable and the non-improvable.

The label "improvable" or "non-improvable" indicated the different values that were attached to each group. The improvable group was seen as having the potential to develop whereas the non-improvable group was regarded as having no capacity to benefit from education. The social values associated with potential can be related to the adult roles that were envisaged for the children in later life. Separation of the two groups suggested that the criteria for distinguishing one group from another were implicitly linked to their ability to acquire the academic skills and discipline required from future workers. The higher value afforded the improvable group was derived from their potential to repay a government, or reduce subsidies from the voluntary sector, by generating an independent income.

Further questioning of Sir Edward Fry solicited his views on the increase of "insanity". His comments were made in the context of the provision required for idiots and imbeciles, which suggests that he saw them as contributing to an increase in the prevalence of insanity:

> (Mr. Hobhouse) In one part of your evidence you tell us there has been a great increase of insanity. Do you derive that from personal knowledge, or from statistics? - It is only the general knowledge which everyone possesses more or less, and the inclination of my mind is to think the increasing number returned is not due entirely to additional care or inspection; it is due really and bona fide to the increase of insanity. That is my impression, but I am not an expert upon the point. [4]

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[3] Roy. Com. Feeb., I, p.316

[4] Roy. Com. Feeb., I, p.318

His views point to the existence of a set of beliefs regarding a rise in the incidence of insanity that had gained widespread acceptance and could pass as "general knowledge". These beliefs would have influenced people involved in the delivery and regulation of services, even if Sir Edward attempted to play them down in his own evidence. His statement also indicates that the material regarded as evidence was likely to incorporate opinions, subjective judgements and any number of unconscious or implicit criteria as well as material that members of the Commission were prepared to accept as facts

In addition to the statements presented by professionals representing the medical and educational services the Commission invited contributions from people that had gained practical experience by delivering or managing services (these people included Sir Edward Fry, Norah Fry[5], Ellen Pinsent[6] and Harold Burden). Their contributions show that professionals did not exercise a monopoly over the development of services. The evidence that the Commission gathered described rising levels of idiocy, imbecility and feeble mindedness. The levels of "insanity" that were anticipated indicated that the figures at their disposal had been underestimated. They also suggested that the existing provision would not be sufficient to accommodate a rapid increase in the number of people requiring specialised services. The combination of these factors created pressure to develop more robust policies and effective administration. Evidence of increased demand, inadequate provision and unmet needs gave momentum to pressure groups and professionals calling for government intervention. The problems around identification, classification, reliable numbers and appropriate services were seen as issues that required action at both national and local levels. Services were required to meet the demand in the provinces as well as the demand in London. The evidence

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[5] Norah Fry had experience of "mental defectives and epileptics" in the Somerset Union (*Roy. Com. Feeb., II, p.225*).

[6] Ellen Pinsent had established a voluntary organisation in Birmingham to find work for feeble-minded school leavers. She collected records from home visits describing the lives of the "feeble minded". The records strengthened her belief in the value of residential care for feeble-minded adults. She became a dominant figure in the Board of Control during the 1920s. See M. Thomson *The Problem of Mental Deficiency Eugenics, Democracy and Social Policy in Britain c.1870-1959* (Oxford, 1998), 16, 84.

presented to the Commission allowed members to deliberate on the advantages of recognising the scale and significance of mental deficiency, as well as the disadvantages of ignoring "the problem", or underestimating the resources that were required to tackle it successfully. The cost and benefits of different strategies were measured by their potential to strengthen, protect or weaken the state, race and nation.

Britain's national identity as the leader of an empire and major trading power depended on the stability of the domestic economy and its ability to remain competitive in international markets. Government played a central role in maintaining the stability of the economy by regulating public expenditure and equipping the workforce. Competitiveness abroad was enhanced by the provision of an educational system that would furnish the working population with the skills that were required for trade and industry. Forster's introduction to the Elementary Education Act of 1870 spoke of the relationship between the provision of elementary education and the development of the skills that were required to remain competitive abroad:

> Upon the speedy provision of elementary education depends our industrial prosperity... if we leave our folk any longer unskilled, notwithstanding their strong sinews and determined energy they will become overmatched in the competition of the world.
> (Cited in Topliss 1979, p.5)

His speech mentioned the need to combine unskilled brawn and energy with the benefits of education. In a competitive world Britain could only sustain a leading position if a sufficient proportion of the population were numerate, literate and capable of conforming to the discipline of regular employment.

The introduction of elementary education had also made a significant contribution to the stability of the economy by providing opportunities for regularly monitoring and regulating the physical, moral and mental efficiency of the population:

> Universal and compulsory education had the function both of revealing and helping to resolve the problems of the appalling standards of physical and moral health of the population. Revealing it because, for the first time, all of the children of the entire population

> were brought into contact with those who could recognise lack of physical and moral well being when they saw it, and saw it with alarming frequency. But also helping solve it because, through the school, it could be diagnosed and remedial measures put into operation.
> (Rose 1985, p.85)

The provision of education had a clearly defined role and function related to the productivity and efficiency of the nation. Compulsory attendance at school brought the whole of the school age population under scrutiny. One of the functions the school performed was regular checks on changes in the physical and moral health of the populations that passed through them. Schools also had a role in ameliorating or correcting problems and deficits by providing a reliable point to implement remedial measures.

This combination of role and function utilised entry into the education system and educational attainment as a means of identifying those who would be able to benefit from the system and make progress and those that could not. Pupils that were able to conform to classroom discipline and learn basic skills had the potential to contribute to the future stability and prosperity of the nation. These pupils were distinguishable from those children who failed to make progress and would not accept the discipline and social norms required in school. In this way the school became an arena for competing ideologies and strategies. Rose (1985, p.85) has described how the conflict between eugenic and neo-hygienist strategies became polarised around issues of segregation and integration. Eugenicists proposed to maintain social stability by separating and segregating groups who threatened it while the neo-hygienists proposed to integrate disaffected groups by implementing educational programmes, processes of socialisation and the inculcation of social norms.

The provision of accommodation for those who were unable, or unwilling, to work created institutions that were comprised of more than bricks and mortar. They were also a potent source of myths and symbols. The buildings provided an imaginary space where those who lived outside of the walls were able to locate their fantasies, fears and anxieties about the people who conducted their lives within them. They also performed an ideological function:

> ... the workhouse represented the ultimate sanction. The fact that comparatively few people came to be admitted did not detract from the power of its negative image, an image that was sustained by the accounts that circulated about harsh treatment and separation of families that admission entailed. The success of "less eligibility" in deterring the able bodied and others from seeking relief relied heavily on the currency of such images. Newspapers, songs and gossip, as well as orchestrated campaigns for the abolition or reform of the system, all lent support to the deliberate attempts that were made to ensure that entry to a workhouse was widely regarded as an awful fate.
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> (Parker 1988, p.9)

Admission to a workhouse, or an asylum, was a symbolic as well as an administrative procedure. Admission signified separation or exclusion from the rest of society. It invited a range of negative interpretations that pointed to the qualitative differences between people who lived outside and those people who were compelled to live inside. The negative stereotypes and labels associated with admission included presumptions about a person's need for control or restraint, their moral stature, their aptitude for work and their capacity to lead an independent life. While the threat of admission served as a warning to eschew improper conduct or idleness it also labelled the people who depended on their services as having less value or status than the rest of the population. They were perceived as being incapable of avoiding an awful fate or unwilling to learn from the experiences of others who had become institutionalised.

Resources and Responsibilities

The establishment of private facilities such as The School for Idiots outside Bath and the asylum founded at Park House, Highgate (under the patronage of the Duke of Cambridge and the Duchess of Gloucester), indicate that both the private and voluntary sectors were involved in the emergence of specialised services. Both of these facilities were established between 1846 and 1847. During 1855 the institution founded at Highgate moved to Redhill, Surrey. It became known as the Earlswood Asylum and by 1881 it had 561 inmates (Jones 1972, p.183). Between 1864 and 1868 the Starcross Asylum near Exeter and the Northern Counties Asylum at Lancaster were opened.

Earlswood, Starcross and the Northern Counties Asylum were subscription hospitals although the latter did make some provision for "children of persons in narrow circumstances". Charges for patients accommodated at the Northern Counties Asylum ranged from 50 to 200 guineas per annum; children of persons in “narrow circumstances” were accommodated for 20 guineas (Jones 1972, P.183).

Sutherland (1984, p.14) has described the state’s involvement in monitoring patterns and standards of care during the early nineteenth century. The Lord Chancellor's Commission in Lunacy was established in 1845 and imbued with the power to inspect, report on, and license madhouses. Scull (1993) has described how small private madhouses became established as successful business enterprises that derived their profit from clients, or families that could afford to pay for care and treatment. While the presence of a few “pauper” patients, whose payments were guaranteed by their local parishes, were welcomed as a way of supplementing their income entrepreneurs did not view provision for poor or impoverished people as a lucrative proposition. Scull (1993. P.21) states that provision for this group only became viable when providers could trade in large numbers, providing accommodation and other services in bulk “wholesale, as it were, rather than retail”. Decisions regarding the separation of asylum patients from the population remaining in workhouses were guided by financial considerations as well as the ideas about curability. While residents in the workhouses received medical treatment the level of medical supervision was not as intensive or expensive as that provided in county asylums. Opinions on the level of supervision that was required divided members of the medical profession. Wright (2000, p.739) has observed that some medical superintendents wanted to distance themselves from any association with custodial care, or the chronically ill, because it was not compatible with the progress of lunacy reform, or the promulgation of a curative medical model. Others regarded the charitable idiot asylums as a model that allowed the development of educational institutions separate from the Poor Law, but still under medical supervision.

Trade

The remainder of this section will examine how economic considerations have shaped the development of welfare. It will go on to look at the emergence of a disabled "category" and describe how the organisation and administration of disability changed the apportionment of goods and services based on principles of work and need. Harris (1993, p.4/5) has suggested that the wealth that Britain accumulated through world-wide trade, and its commitment to the colonies, made it both powerful and vulnerable:

> The very fact of British economic and political power in the wider world was in itself a major determinant of the character of domestic society throughout the period, perhaps more markedly so in the 1900s than in the mid-Victorian era. Between 1870 and 1914 Britain extended and consolidated her sovereign and informal influence in many parts of Africa and Asia. She fought continuous colonial wars and won most of them. Her Royal Navy policed the seven seas, keeping routes open for global free trade (including her commercial rivals). During the 1880s Britain lost her position as the undisputed leader of the world's industrial powers, but down to 1914 she was still by far the largest trading and carrying nation. London became and remained the major discount centre, clearing house and capital market of the world.
>
> This global activity as a great imperial and trading power reacted upon society at home in a myriad different ways. The absolute commitment of British governments to international free trade (a commitment challenged but not toppled in the 1900s) meant that, more markedly than anywhere else in Europe, British society was vulnerable to the perpetual changes wrought by the pressure of world markets. There were many countervailing pressures of locality and custom, but in the last resort patterns of employment, settlement, taste, consumption and value were all subordinate to the pursuit of "comparative advantage".

Harris' account has emphasised that Britain was susceptible to fluctuations in world markets. Under these circumstances a well-educated and productive population was a source of stability and a defense against rival nations. The contribution that they made had to be weighed against any demands placed on the domestic economy by those who were deemed ineducable and unlikely to engage in any form of productive economic activity.

Employment and Disability

In a society where the pursuit of comparative advantage was paramount the presentation of economic arguments, rather than pleas for individual contentment, or humanitarian concern, were most likely to win support from government. Topliss (1979, p.7) has expressed the view that widespread belief in the value of economic rationality meant that proposals for welfare provision advocated on the grounds of economy, good management and efficiency were more likely to secure resources than proposals that emphasised humanitarian motives. The proposals that were most likely to succeed were those that allied the interests of disabled people, or specific groups in the population of disabled people, with the wider interests of society:

> Such measures as are operative are mostly those where the cost of providing the service to the disabled could clearly be seen to be effective in enabling the recipients, or a sizeable proportion of them, to become functioning members of the productive life of society. Where such an outcome could not be anticipated, as for example in the cases of very severely handicapped persons, the inadequacies of provisions to meet their needs are glaringly obvious.

Economic rationality linked employment and unemployment with productivity and the boundaries that defined a person's social value. The ability to secure employment indicated that an individual was capable of becoming a "functioning member" by making a regular contribution to the productive life of society. When there was little prospect for disabled individuals becoming functioning or productive members of society the resources that were allocated for their maintenance were drastically reduced.

Rose (1985) has also described how administrative categories were created to establish boundaries between the employable and the unemployable. One of the functions of such boundaries was to guide the former towards the benefits and discipline of regular employment and administer corrective measures to latter. In 1905 Beveridge expressed the difference between the two groups in terms of those who were fit to join the industrial army and those who were parasites:

> It is essential to maintain the distinction between those who, however irregularly employed, are yet members, though inferior members, of the industrial army and those who are mere parasites, incapable of performing any useful service whatever.
> (Cited in Rose 1985, p.51)

He went on to propose that employment should be established as the criterion that divided those who were entitled to full membership of society from those who were not entitled to membership. Those who were employable were to accrue the benefits of full employment rather than casual labour, average earnings, civil and political rights whereas those who were unwilling or incapable of work had to be:

> removed from free industry and maintained adequately in public institutions, but with the complete and permanent loss of all citizenship rights - including not only the right to franchise but civil freedom and fatherhood.
> (Beveridge cited in Rose 1985, p.51/52)

People with learning disabilities that were not employable were characterised in a disparaging manner because their relationship to the workforce, and the economy, was regarded as parasitic. Their exclusion from the labour market meant that they were unable to earn wages so they could not afford to purchase the range of goods and services that were available to wage earners. A higher standard of living was seen as a reward that belonged to people that had earned or saved sufficient money to acquire it. In addition Beveridge argued that the qualitative differences between those who were employed and those who were not should include the franchise, civil freedom and fatherhood as well as the material comforts of a home and home ownership.

Stone (1984, p51) associated the construction of a disabled category with the rise of capitalism and rationalisation brought about by more complex systems of bureaucratic organisation and administration. She has argued that the system of categorical exemptions from work, and entitlement to benefits that existed at the end of the nineteenth century was an attempt to develop coherent policies that would "reconcile the distributive principles of work and need without undermining the productive sides of the economy". She views the Poor Law Amendment Act of 1834 as a watershed in the development of welfare related

policy because it established three new principles: "national uniformity in welfare administration, denial of assistance outside the workhouse, and deterrence as the basis for setting benefit levels" (Stone 1984, p.38). Oliver (1990, p.40) has stated that this attempt to resolve the "distributive dilemma" changed peoples' conception of disability, as well as the ways in which people with disabilities received goods and services:

> The major mechanism of distribution (and production) is work, but not everyone is able or willing to work. Thus a distributive system based on need will also exist and the "distributive dilemma" centers on how to allocate goods and services based on the very different principles of work and need. With the rise of capitalism, disability has become an important boundary category through which people are allocated either to the work-based or needs-based system of distribution. The increasing specialisation of both categorisations and provision is thus a function of the increasing rationalisation of the world.

The development of a needs-based system necessitated the growth of a specialised bureaucracy and administration which had a clearly defined role in the regulation and distribution of goods and services. The roles and functions of these organisations were different from those of the work-based system. The differences between the two systems included the characteristics that were attributed to people who used the services. While those who worked to secure goods or services were perceived as valuable members of society who earned full rights of citizenship, those who received goods or services based on need, without earning them, were seen as inferior, and described as "parasitic" or a "burden". The boundary, which separated the work and needs-based systems, also indicated whether people were likely to be categorised as worthy of contempt or commendation, deserving or undeserving, valuable or useless. In addition to these differences there were substantial differences in the quality of goods and services offered by the two systems, and the lifestyles they afforded. While those who worked could alter the quality of their lives through their own labour and retain goods and property through private ownership, those who derived goods and services based on need became more dependent on charitable provision, philanthropy and public expenditure.

A competitive system, which emphasised the value of individual merit and private ownership, was bound to create winners and losers. People with a learning disability were not excluded from participating per se. but the provision of elementary education for all, and the development of welfare created a two-tier system. The first tier included those who were seen as capable of making an active contribution to the life of the community and the wealth of the nation. The second tier comprised those who could not. They were perceived as consumers of the nation's resources and outsiders rather than contributors. Those who could not contribute to society, and were deemed to have no potential for improvement or development, were clearly set aside from the others. In the evidence that he put before the Royal Commission in 1905 Charles Fox[7] introduced his remarks with the following statement on the Commissioners' need to bear in mind the nation's wider interests:

> Before submitting any proposals to your Committee, it is evident that they must have regard first to the best conditions possible for the individuals so afflicted, second to the wider interests of the nation both in the present and future generations, as the propagation of such unfortunates is cruel both to the offspring and to society in general, and therefore must be, if possible, prevented. [8]

This evidence established a context in which decisions concerning resources and responsibilities were made. While Fox states that the Commission should have regard to the best conditions possible he also states that these conditions were circumscribed by the wider interests of the nation. He went on to suggest that while provision should be the best "possible" it should be given with the proviso that it did not become a recurrent burden on future generations.

Resources for people with disabilities, whether they came via statutory agencies, private, or voluntary organisations, were derived from a process that involved competition between different groups. While groups that held out the prospect of rejoining the "productive" sectors in society were in a strong position, people with more severe disabilities were in a weaker position.

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[7] Charles Fox was representing Somersetshire County *Council (Roy. Com. Feeb., II, p.IX)*. He was also Chairman of the Somerset, Bath and Western Counties Asylum, a Guardian of the Wellington Union, and a member of the Somerset County Education Committee (*Roy. Com. Feeb., II, p.30*).

[8] Roy. Com. Feeb., II, p.30

Resources dedicated to people that could recover, or maintain themselves, were viewed as recoupable, whereas resources that were used to sustain people that could not maintain their independence were perceived as a "tax" on the labour of productive members of society. Paradoxically groups perceived as a threat to the established social order were likely to receive a share of resources that was not linked with the prospect of recovery or repayment. The money was perceived as a way of limiting the damage that would ensue if supervision or confinement were not available. Towards the end of the nineteenth century "idiocy" and "moral degeneration" were construed as threats that required control and confinement. To expedite the process there were proposals to develop "mental deficiency" services that were separate from the services provided for the insane, the impoverished and those people convicted of criminal offences.

Conclusion

This chapter has examined the development of services for people with learning disabilities between the middle of the nineteenth century and the beginning of the twentieth century. During this period most people with learning disabilities lived in the community with families. People living in institutions were divided between different services. The services that were available included prisons and a limited number of places in county asylums, Poor Law union workhouses and small private institutions. Specialised services were scarce. Public funds to support places in asylums and private institutions were restricted so that a basic system of streaming was developed in order to allocate resources to those individuals or groups that had been identified as a priority. People labelled as "insane", "dangerous", or "curable" were moved from workhouses to occupy more expensive places in county asylums. The prospect of curing the individual, or isolating violent and disruptive individuals, was perceived as an outcome that justified more expenditure. Individuals deemed to be harmless or incurable remained in workhouses where it was unlikely that they received a specialised service. Similarly the introduction of special education facilitated the removal of disruptive pupils, and children labelled as "ineducable", from mainstream educational services. In the case of

special education the cost of establishing separate classes or services for a relatively small group was justified by pointing to the benefits that would be available to the majority of children remaining in the classroom once the mentally deficient children had been removed.

Although the evolution of specialised services has been viewed alongside the growth of professions the activity of professionals needs to be seen in the context of widespread social change. In this chapter a range of social, political and economic factors have also been considered. Britain's eminence as a trading nation and its commitment to a succession of colonial wars meant that production, consumption and economic management exerted a strong influence over the development of foreign and domestic policy. The expansion of free trade, the accumulation of private capital, and a desire to protect the privileges associated with class and status, together with concerns about threats to Britain's prestige combined to produce long term strategies for controlling and containing deviancy. The implementation of these strategies led to the extension of bureaucratic mechanisms of control connecting central and local government, professionals working in a variety of different services, and a tier of influential individuals that operated in the private, voluntary and charitable sectors. As a result of these changes some of the divisions that separated different social strata were strengthened. Although the introduction of compulsory elementary education meant that a broader section of the population was able to benefit from basic education it also meant that the status of those people that were labelled as "ineducable" deteriorated. Similarly the introduction of medical inspection and routine health surveillance in schools meant that some problems were detected and ameliorated. At the same time the boundaries separating those who where identified as healthy and able bodied, from those labelled as "unfit" or "disabled", were more clearly defined.

Specialisation necessitated sifting and sorting of the population to identify users, and potential users, of the services. This chapter has identified the measurement of intelligence, judgments about peoples' eligibility for work, their capacity to lead an independent life, and the construction of a "disabled" category, as criteria that were used to separate people with learning disabilities

from the rest of the population. In the professional domain medicine established a strong presence in the specialised services that emerged, but it did not develop a monopoly in the way that psychiatry dominated mental illness. The absence of any treatments that held out the prospect of a cure meant that physicians could not make direct analogies with other branches of medicine. A reluctance to apportion resources to mental deficiency services meant that they were less prestigious than the services for people with mental illness, and a long way behind services provided for more "mainstream" health needs, consequently there were fewer incentives to attract innovative practitioners into the field. Without the pressure to provide facilities for expensive treatments, the Home Office and local authorities were able to make use of a wide range of service providers. The development of a "mixed economy" incorporated specialised care and treatment in asylums and more basic accommodation in workhouses. Specialised services providing training included the Darenth Training Schools established by the Metropolitan Asylums Board in the 1870s, as well as smaller institutions that combined public funding and private initiatives. The mixed economy allowed the state to divert some of the costs for developing new services, or converting existing provision, to private providers.

The next chapter will focus on Harold Burden and Stoke Park. The establishment of an industrial school on site, and the growth of Stoke Park Colony, provide an example of a partnership that combined public funding with private management and ownership. Correspondence between Burden, Sir W. Byrne and Dr. R. W. Branthwaite has shown that the Home Office was eager to stimulate growth in the private sector. Analysis of Burden's correspondence with the Home Office, and other people connected with the National Institutions for People Requiring Care and Control (NIPRCC), has revealed conflicting views of the man and the institutions that he managed. The chapter will also examine Burden's work on the Royal Commission (1905). Analysis of the questions that he posed reveals his interest in exploring the advantages and disadvantages of different models of service provision. The value of his previous experience as a supplier of cheap accommodation in reformatories for

inebriates, and the significance of his contribution as one of a number of lay people on the Commission, will also be explored.

Chapter 2

Stoke Park 1909 - 1916

The previous chapter focused on events that marked the emergence of specialised services for people with learning disabilities. This chapter will examine the micropolitics of service delivery at a local level. It will focus on people and events at Stoke Park in Bristol. Material has been derived from documentary sources that included personal correspondence, memoranda, minutes from meetings, reports, and personal notes. Analysis of the material has pointed to the strength of the relationship between Harold Burden and the Home Office, and the more ambiguous relationships that developed between Burden and individuals that had direct contact with him through their involvement with the NIPRCC. Material in this chapter will also explore how Burden was able to use the knowledge and experience that he had gained from his early work with inebriates, as well as his subsequent work with the Royal Commission, to expand the Stoke Park Colony. Particular attention has been paid to the period between the Royal Commission and the implementation of the 1913 Mental Deficiency Act because this period was marked by a rapid increase in the accommodation and facilities available on site.

Stoke Park was the name given to the site in Stapleton, Bristol but the Stoke Park group included buildings and land in Horfield, Hanham and Clevedon. The main house on the estate opened as a school in April 1909. It was licensed as a Special Industrial School under section 62(2) of the 1908 Children's Act. The report from the Commissioners for Reformatories and Industrial Schools in July 1909[1] stated that Stoke House School for Mentally Defective Girls provided accommodation for ninety girls, and Ivy Lodge School for Boys accommodated sixty boys. Between 1909 and 1916 the site was expanded from a school to a colony. The construction of new buildings and the modification of existing buildings denoted a dramatic increase in the size and scale of provision, as well

[1] CRIS Annual Report 1909, p.228

as an escalation in the number of residents. By 1916 the report from the Board of Control[2] stated that Stoke Park was "the largest institution of any devoted to the care of the Mentally Defective person". In addition to the buildings on the original site the group had also expanded to incorporate the Royal Victoria Home, Brentry, Beach House, Stapleton, Clevedon Hall, Somerset, Heath House and Hanham Hall in Bristol. There were also arrangements in progress to assimilate Leigh Court into the group. The report stated that (excluding Leigh Court) there was accommodation for 1,268 people.

Concepts, Definitions, and Characteristics That Have Been Used to Identify People with Learning Disabilities

The social and political climate that surrounded the opening of the voluntary institutions in the 1840s, 50s and 60s had started to change by the end of the century. A feeling of optimism that had focused on the educability of idiots was fading. Enthusiasm engendered by the work of Itard, Seguin, and Guggenbuhl[3] that had led to the establishment of training schools like those at Bath and Darenth, was petering out. A corpus of beliefs that enumerated the rehabilitative and redemptive powers of education had lost credibility. It had been hoped that basic skills training would prepare the feeble minded for an independent life. Thomson (1998, p.12) states "there was now far less confidence in educating them to earn a living outside the institution than there had been earlier in the century". Concerns about mental and moral degeneration, such as those propounded by the psychiatrist Henry Maudsley[4], and public debate about the

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[2] BOC Annual Report 1916, p.49

[3] Guggenbuhl was the founder of the first European residential school for idiots, and one of the first people to use the term "colony" to describe the site of care for people with learning disabilities. He believed that colonies could be used to cultivate a healthy environment that would assist recovery. Guggenbuhl made claims for the humanity of "idiots" that emphasized their capacity for improvement through education. In 1939 he attempted to cure "cretins" by taking them away from the Alpine valleys and moving them to the restorative environment of the mountains. See N. Rose *The Psychological Complex* (London, 1985), 95, J. Ryan and F. Thomas *The Politics of Mental Handicap* (Harmondsworth, 1980), 92, D. Pick, *The Faces of Degeneration: A European Disorder, c.1848-c.1918* (Cambridge, 1989), 45-7, and M. Thomson *The Problem of Mental Deficiency Eugenics, Democracy and Social Policy in Britain c.1870-1959* (Oxford, 1998), 114.

[4] Degenerationists like Maudsley warned that the number of people inheriting "weak minds" was increasing. The presence of a weak mind was associated with anti-social behaviour and criminality. At first Maudsley had believed that degeneracy was self-limiting with each generation moving towards

relationship between the residual population in asylums, prisons and workhouses and the structure and status of the rest of society, found expression in fin de siecle pessimism. The visibility of mental defectives within the education system following the introduction of universal elementary education in 1870, and the passing of the 1899 Elementary Education (Defective Children) Act, fuelled public debate and anxieties surrounding the escalating number of children that fell within its remit. This was accompanied by scientific discourse that conjoined heredity, lunacy and social Darwinism. The Royal Commission was conducted in an atmosphere where optimism was more likely to be expressed in terms of economy, or the management of resources, rather than the transformation of the defective individual. While the Commission gathered evidence the wave of social and political activity that resulted in the Eugenics Education Society was gaining momentum. The Society was founded in 1907, the year before the Commission published its report. Thomson (1998, p.33) has said that this was not coincidental. He has stated that the report was a stimulus to, as much as a direct product of, the eugenics movement.

The brochure for Stoke Park, and other institutions in Burden's group, set out objectives for the Colony[5]. It combined references to the value of providing training with references to the provision of custodial and permanent care. The brochure stated that "congenital mental defect is an incurable condition"[6] but children that were incapable of benefiting from ordinary education could be improved by the special training available in an Industrial School. The work that had generated so much optimism earlier in the previous century was also mentioned. The brochure went so far as to state that if it could be achieved in America and Germany " we can do it in England"[7]. However evidence of any

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impotence and sterility, see H. Maudsley, *The Physiology and Pathology of Mind* (London, 1868), 246-7. At the end of the nineteenth century ideas about degeneration changed so that the argument about breeding and degeneracy was reversed. It was perceived as more threatening when degenerationists began to claim that those with pathological conditions were reproducing at a greater rate than others. See N. Rose *The Psychological Complex* (London, 1985), 60, D. Pick, *The Faces of Degeneration: A European Disorder, c.1848-c.1918* (Cambridge, 1989), 203-16, and M. Thomson *The Problem of Mental Deficiency Eugenics, Democracy and Social Policy in Britain c.1870-1959* (Oxford, 1998), 20.

[5] BRO 40686/PM/8(b) p.3
[6] BRO 40686/PM/8(b) p.4
[7] BRO 40686/PM/8(b) p.4

optimism of this nature was countered with allusions to permanent care and control that were redolent of fin de siecle pessimism. Although residents were able to learn small, daily tasks that contributed to the "general comfort of the community"[8] the brochure emphasised that they were not being equipped with skills so that they could lead independent lives outside of the institution. It stated that without a disciplinary regime and proper supervision the residents would revert to criminality and pauperism:

> But it is important to remember that these same people turned out into the world to fend for themselves would at once cease to do any useful work. Not only would they fail to support themselves, but they would extort from the community a most expensive form of support as criminals and paupers. Permanent care and control is the only method of securing economical and humane treatment.[9]

Streaming and Classification

Although Stoke Park was licensed as a Special Industrial School the institution was multipurpose. The 1911 brochure for the National Institutions[10] stated that the Colony had been set up to provide custodial care for children directed there from the Education Authorities and the Boards of Guardians. The brochure also claimed that the registers showed over a quarter of the total number of Poor Law Authorities in England were maintaining cases in the National Institutions. Describing the reason for establishing the colony the brochure stated that it aimed to provide care for three groups of mentally defective children. The groups comprised mentally defective children living in very bad homes, mentally defective children that were not able to attend a day school regularly, and mentally defective children referred to as moral defectives. Although the brochure specified three different sets of circumstances under which children were likely to be placed in institutional care it did not specify how the resources at the Colony would be used to meet the particular needs of each group. Care was not constructed around individualised plans or packages other than the overall cost of maintaining a bed. The concept of care and control was used to

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[8] BRO 40686/PM/8(b) p.4
[9] BRO 40686/PM/8(b) p.4
[10] BRO 40686/PM/8(b) p.3

highlight deficits in a child's home life, upbringing or school. In each case the method of redressing these deficits was the same; all of the children would benefit from the daily routine, supervision and discipline provided by residence in the Colony. In the case of children living in bad homes a place in the Colony would ensure that they were removed from any "bad influence" that would lead to the acquisition of "vicious habits"[11]. For children who wandered or "children of parents that did not enforce their children's attendance at school"[12] the Colony provided a level of supervision that the parents had not been able to provide. In the case of children labelled as morally defective a place in the Colony would ensure that they were removed from "all opportunity of vice" and placed under "suitable control"[13].

Because one of the objectives of the institution was to provide permanent care it was unlikely that the license as a school would circumscribe all of its functions. It was more likely that the managers saw the admission of children as the point at which an individual would enter the Colony. Permanent care meant that the amount of time a person spent there would not be prescribed by "childhood". The managers of the National Institutions set out to create a multipurpose environment that extended beyond the provision of education and accommodation for children. In this respect the "dynamic" at Stoke Park was different from the dynamic in the other asylums. There was a general agreement among the superintendents and medical staff in the other asylums that they should be a focal point for education and training during the early years (Gladstone 1996, p.141/2). The original intention was for asylums to admit children for a maximum period of five years and not to retain them beyond the age of 15. In reality this intention had not been realised:

> But by the end of the nineteenth century that aspiration was already beginning to be in contrast to the practical reality of Asylum. In 1898, for example, only a minority (125) of the inmate population (282) at the Western Counties were aged between 5 and 15; the remainder were all older, 64 being aged 20 and upwards.

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[11] BRO 40686/PM/8(b) p.3
[12] BRO 40686/PM/8(b) p.3
[13] BRO 40686/PM/8(b) p.3

A similar situation prevailed in other parts of the country. Asylums were reaching capacity because the population could not find accommodation or employment outside. Earlswood had reached capacity in 1866. It increased its' capacity to 600 residents and then reached capacity again in 1878. Although the impetus towards permanent care had been driven by a desire to extend supervision and control into adulthood it was also an admission that, in practical terms, there was nowhere else for people to go.

The Managing Committee and the Superintendent of the Western Counties, unlike the managers at Stoke Park, attempted to protect the role of the institution as a provider of education and training. This role was clearly separated from a custodial role. To prevent an influx of "helpless and unimprovable idiots" the institution adopted a selection policy (Gladstone 1996, p.148). By implementing procedures that included giving subscribers an entitlement to vote on the election of potential inmates or patients the Western Counties managed to separate "improvable idiots" from the rest. Rejection of those inmates that were less able had helped to maintain its role as an educational establishment. It had also helped the Committee to present a positive and progressive image to the public and subscribers, and to use the labour of the more able inmates as an integral part of their economic strategy. Although Stoke Park had been certified as an industrial training school the way in which it approached admissions shows that its modus operandi was fundamentally different from the Western Counties.

The provision of "custodial care" had been proclaimed as a legitimate objective of the Institution. By 1911 the financial strategy that had been developed by Burden, and the managers responsible for the N.I.P.R.C.C. directed services towards the largest number of potential service users. The benefits that could be derived from larger numbers and economies of scale encouraged them to provide residential services for less able inmates. Instead of operating a rigorous selection policy Stoke Park made provision for both educable and the

ineducable residents. When the Industrial Schools Inspector had visited at the end of 1910 the Report stated:

> When children are found to be too defective for either school training or industrial training to be of benefit, Stoke Park provides facilities for permanent care under most humane conditions. The Institution is meant for educable and uneducable, it being necessary for the latter to be cared for as the former. [14]

A passage in the 1911 brochure mentioned the movement of inmates between the institutions that belonged to the N.I.P.R.C.C. group[15]. A system for sorting and classifying inmates had been developed while the National Institutions were still functioning as inebriate reformatories. It had been used to facilitate the use of different sites for groups of the same sex, age or ability. Stoke Park took the infants; girls and boys aged 2-10, and girls aged 2-25. After that boys were moved to Sandwell Hall that required an admission age of 10-15 and then to East Harling, which admitted boys aged 15-25. Girls aged 15-25 could also be admitted to Ackworth (and later Chesterfield). Utilizing different sites, within a cluster of institutions, to accommodate different groups mirrors the system that was established in London by the Metropolitan Asylums Board (MAB) prior to the implementation of the 1913 Mental Deficiency Act. The scheme developed by the M.A.B. grouped people by age and degree of mental defect (Thomson 1998, p.234); colonies for the aged were provided at Tooting Bec, the very young at Fountain, the low-grade at Leavesden and Caterham, and the able bodied and high-grade at Darenth.

The 1911 brochure produced by the NIPRCC stated that young and "possibly improveable" cases would be retained at Sandwell and the "older and less improveable" cases would be sent to Stoke Park[16]. Streaming the inmates according to their age and capacity for improvement, and their subsequent passage between different institutions, pointed to the specific role that the Colony had acquired within the group. The Colony admitted those cases that required a level of care or supervision which made it difficult for them to be

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[14] CRIS Annual Report 1910, p.226
[15] BRO 40686/PM/8(b) p.2

placed in other institutions. Comments made in the Industrial Schools Report from 1915 regarding the Stoke Farm Reformatory indicate that this type of provision was fulfilling a need that had not been met in other institutions. The report stated that:

> The need for a Special Reformatory School for boys suffering from physical defects of all kinds is still as great as ever, although the Managers of the Stoke Farm Reformatory continue their benevolent action in accepting boys for whom admission could not be obtained elsewhere.[17]

The report from the Board of Control in 1916 noted that the administration was animated with a desire to develop and extend the usefulness of the Colony. To expand its provision for boys work had commenced on Heath House. The adaptations would mean that more of the "bigger boys" would be available for "out door work" and work on the farm[18].

By 1916 the Colony had expanded so that it occupied a dominant position in the national network providing services. The Board of Control report for that year recognized that it was the largest institution specializing in the care of "mentally defective" people. Statements in the report attributed its' capacity for growth to the managers' attitude towards admissions. Unlike other institutions Stoke Park stood alone "in the willingness of the Managers to admit for care therein all types of defective from the lowest to the highest grades"[19]. While other managers had produced policies for admission that aimed to restrict admittance to people selected from the higher grades, the managers at Stoke Park had consolidated a key position amongst service providers by developing a policy that aimed to include residents from the lowest as well as the highest grades. The Board of Control described their willingness to accept a proportion of cases from the lower grades as a "pubic spirited and commendable"[20] action. At the same time it had been profitable for the managers to adopt this strategy because it had established a unique role for the services provided by the

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[16] BRO 40686/PM/8(b) p.2
[17] CRIS Annual Report 1915, p.25
[18] BOC Annual Report 1916, p.50
[19] BOC Annual Report 1916, p.49

Colony. In addition it had generated a regular and reliable income that had been invested in the site to enhance its' durability. Although the Board's report showed its' approval of the situation it also contained a suggestion that the Manager's actions may have repercussions that would lead to problems for them later on. The Report stated that when the Managers were able to comprehend the significance of these difficulties the Board trusted that it would not lead them to deviate from the course they had adopted.

Although the Colony had secured a prominent position amongst the providers of services it was not protected from the impact of changes that reverberated throughout the national network of institutions. As well as coping with the demands that the lower grade inmates continued to make on the Colony's resources it also had to adapt its practices on admission to accommodate the movement of inmates between institutions. During 1913 and 1914 the Colony made transfers of inmates to the Eastern Counties and Midland Counties Asylums and to Sandwell, another institution within the N.I.P.R.C.C. group. The transfers suggest that the inmates were moved to facilitate the accommodation of large groups of boys or girls on different sites and to reconstitute different groups in accordance with the inmates' needs and abilities. Girls were moved from Stoke Park to the Eastern Counties Asylum in January, March, April and September during 1913[21]. Boys were moved to the Midland Counties and Sandwell in December of that year and February of the following year. During 1914 boys were also moved to the Eastern Counties and Sandwell[22]. This succession of transfers between Sandwell and Stoke Park group corroborates the directive to divide the inmates between the two institutions so that the older and "less improveable" cases were retained at Stoke Park while the younger, improveable ones were sent to Sandwell[23]. A directive from 1914 regarding the age of admission[24] stated that boys between the ages of 2 and 10 years would be admitted, and girls between the ages of 2 and 25. It went on to specify that only feeble-minded children would be admitted, "Children who are of lower

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[20] BOC Annual Report 1916, p.49
[21] 1913 BRO 40686/NI/2 g
[22] BRO 40686/NI/2 h
[23] CRIS Annual Report 1915, p.25

mental grade ... should in no case be sent"[25]. This would appear to contradict the ethos of an institution that had been praised for providing care for "the educable and the uneducable"[26]. It would suggest that the managers had become more conscious of the cost of maintaining less able inmates. When the cost of maintaining the less able inmates threatened to exceed the resources that were available they were compelled to generate a higher income from the resident population, or limit the demand on resources by imposing a restrictive policy on admissions.

During April 1916 Stoke Park admitted forty-five boys following the closure of the Eastern Counties Asylum, a further sixty-five inmates (mainly boys) in October, and an additional twenty-five in November. The closure and subsequent admissions suggest that other institutions were having difficulties maintaining financial stability following the demand for more comprehensive services engendered by the Mental Deficiency Act of 1913. A disagreement between the Bristol Mental Deficiency Act Committee and Harold Burden indicates that Stoke Park was under similar pressures but evidence recorded in the minutes suggests that he had the resources, bargaining power and connections to overcome them. The minutes for February 23, 1917 record that a deputation had been sent to Stoke Park following complaints from parents about "the unsatisfactory condition of their children"[27]. The minutes for February 27, 1917 note the Committee's concern about medical attendance at Stoke Park following an inquest on the body of a young girl[28]. The Committee suggested that the Board of Control might wish to instigate an enquiry into the "administration" of the Colony[29]. Mr. Burden retaliated in April by complaining about the type of "cases" that were being sent to the Colony. In September he told the Committee that they had sent too many "low-grade cases" and threatened to terminate their contract unless the inmates were removed[30]. The disagreement appears to have been resolved by transferring some inmates to

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[24] BRO NIPRCC: Short Particulars 1914, p.64. Uncatalogued
[25] BRO NIPRCC: Short Particulars 1914, p.64. Uncatalogued
[26] CRIS Annual Report 1910, p.226
[27] BRO 09770 p.80/1
[28] BRO 09770 p.83
[29] BRO 09770 p.84

Reentry (another institution where Harold Burden was the Honorary Secretary), revising the fees upwards, and securing a promise from the Committee that they would send no more low grade cases to Stoke Park.

The Role and Function of Services

Harold Burden's membership of the Commission, and the opening of Stoke Park, had denoted a significant change in the direction of his philanthropic activities. Once he joined the Commission he concentrated his efforts on the care and control of mental defectives rather than inebriates:

> The work was begun among the inebriates, but as a result of Mr. Burden's membership of the Royal Commission, Mr. and Mrs. Burden who were working closely with the Home Office, shifted the work altogether to the care of mentally defectives ... Mr. Burden preferred to settle all ... points (of setting up this trust) with the late Sir W Byrne, who then occupied a high post among the permanent officials of the Home Office ... At that time the intimacy of the connection between Mr. Burden and the Home Office permanent officials was very great and the Home Office was much concerned in the initiation of the work and the lines upon which it was being carried out.
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> (NIPRCC instruction to the Legal Council cited in Carpenter 1996, p.207)

Burden's change of direction followed the groundswell of public interest in the problems that were attributed to mental deficiency. It also coincided with a drop in the income that he had derived from the National Institutions for Inebriates. During 1906 the treasury reduced its contribution for maintaining non-criminal inebriates from 10/6 to 7/-. The county councils objected to an increase in their payments to settle the difference. London County Council, one of the main councils that used inebriate reformatories, cancelled its contract with the Burdens in 1908. The 1908 Report of the Departmental Committee as to the Operation of the Law relating to Inebriates and their Detention in Reformatories and Retreats[31] established that the inebriate reformatory movement had only had a minimal and localised impact on a limited number of councils, with only

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[30] BRO 09770 p.96
[31] Evidence, p.1-11

35 out of 400 having made provision for inebriates. Due to the limited income that was available from this source the Burdens ran down the number of inebriate inmates in their institutions between 1909 and 1914[32]. As the number of inebriate inmates declined the Burdens refilled their Institutions with the Mentally Defective. During 1910 Burden changed the name of his group from the National Institutions for Inebriates to the National Institutions for Persons Requiring Care and Control. Burden's commitment to the developments at Stoke Park also reflected his confidence in the availability of the resources that would be required to expand the site and provide staffing. Evidence submitted to the Commission, and lobbying from the voluntary sector, indicated that the development of specialised services across the country required intervention and support from the state. This was a response to changing perceptions of the size and scale of the problem. In addition to the anxieties that were being aired in public concerning the links between mental deficiency and moral, social, and racial decline, Commissioners were faced with the logistical problem of developing a national strategy to manage large numbers of people within a single, specialised service.

Membership of the Commission gave Burden an opportunity to evaluate the existing services as well as an opportunity to pursue his own interests. Ellen Pinsent heard about his work with the Certified Inebriate Reformatories while she was working with the Royal Commission. She was aware of the trust that the Home Office had placed in him through his office as Warden of these Institutions. He was spoken of as "a great philanthropist and the most excellent and economical of managers"[33]. During 1906 Burden made the following proposition:

> ... that, if I find him 50 feeble minded children and a local Committee he would establish an Institution at Sandwell; that he would provide all the capital outlay necessary, including furnishing, and would make a maintenance charge in Local Authorities who sent children.[34]

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[32] BRO 4068/NI/2 c-h
[33] PRO ED 32/187 (50764), Statement compiled from notes made by E. Pinsent, October 7, 1909
[34] PRO ED 32/187 (50764), Statement compiled from notes made by E. Pinsent, October 7, 1909

At the time Mrs. Pinsent had presumed that the capital required to establish Sandwell Hall was a gift. A year later she found out his motive was entrepreneurial rather than philanthropic. The maintenance charge included interest on capital and a sinking fund sufficient to repay the initial outlay during a limited number of years. During the Commission Burden also used statements form witnesses to gather specific information about the most appropriate means of meeting the demand for services in and around Bristol. The questions that he asked Mary Clifford[35] demonstrated his interest in her views on the type of provision that would be required in Bristol in the future. He began by seeking her opinion on the suitability of using buildings in conjunction with the existing workhouses[36]. He was also interested in her views on the establishment of extensive colonies for the feeble-minded[37]. Burden went on to ask her if she thought that a colony for 300 would be adequate for a town like Bristol. She told him that she did not think that provision on this scale was commensurate with demand. She stated that "we are going to provide for a great many more than that in the case of imbeciles"[38] although she refrained from providing a total figure.

Burden's questions to Charles Fox revealed his interest in ascertaining the value of a specialised service, and the best location for a service of that nature. Burden began by asking whether the witness was in favour of permanent detention. Once this had been established he wanted Fox's opinion on the most appropriate way of providing permanent care. When Fox stated that he believed that persons of unsound mind could be accommodated in a county asylum rather than a "separate place"[39] he asked "Then you should make those persons who are of feeble mind practically lunatics, would you not?"[40]. Burden pursued this line of enquiry by seeking additional information on matters concerning the classification of feeble-minded persons and lunatics. He also

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[35] Mary Clifford was a Guardian first of the Barton Regis Union, and then of the Bristol Union (*Roy. Com. Feeb., II, p.IX*).

[36] Roy. Com. Feeb., II, p.302
[37] Roy. Com. Feeb., II, p.303
[38] Roy. Com. Feeb., II, p.303
[39] Roy. Com. Feeb., II, p.31
[40] Roy. Com. Feeb., II, p.31

asked for Mr. Fox's views on enlarging existing institutions or starting "fresh" ones[41].

The evidence that the Commission gathered from Sir Edward and Norah Fry related to their experiences in Somerset. Burden's questions made reference to the size and scale of institutional provision, and the roles that different authorities should adopt regarding the provision of resources. He questioned Sir Edward Fry about the benefits of small and large institutions. During the enquiry he asked if institutions that provided accommodation for 1000 or 2000 people were too large[42]. He also asked whether responsibility for institutions should rest with the local authority, county council or the State[43]. Edward Fry expressed his preference for county councils and local authorities rather than the state. Responding to a previous question from W.P. Byrne he had also expressed a preference for co-operative work among voluntary agencies rather than a central Government department[44]. Norah Fry took a different view. She could not envisage the voluntary sector providing services that were capable of supporting the increasing number of mentally defective users. Although she saw the advantages of a mixed economy, which included the voluntary sector, she envisaged the State as the main provider of services:

> What you really wish to see then is a voluntary effort supplemented by some State or local institution? - Yes. I am not quite sure that there would have to be State institutions supplemented by voluntary effort. I think the larger number would have ultimately to be supported by the state, if the number is what it appears to be.[45]

In her opinion the State was required to play the leading role while the voluntary sector supplemented its efforts. The demand placed on the service by a large number of service users was a decisive factor in relegating voluntary agencies to a secondary role. Her concluding comment suggested that the scale of the enterprise required a level of funding, administration, planning, and regulation that necessitated the involvement of the State and central government.

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[41] Roy. Com. Feeb., II, p.31
[42] Roy. Com. Feeb., I, p.317
[43] Roy. Com. Feeb., I, p.317
[44] Roy. Com. Feeb., I, p.313

The memorandum that Harold Burden attached to the Commission's final report expressed his appreciation of the need to work co-operatively with the Government. He stated that he wished to give prominence to the Government's need to exercise "strict control over the establishment of institutions"[46]. The strategies he adopted for conducting business relating to the organisation of his Trust also involved working closely with the Home Office. When the Report was completed Burden was able to use his knowledge of the services, and the links that he had established with individuals and government bodies, to assist him in the advancement of Stoke Park. He was able to move his ideas for the development of the site beyond the resources that were available through voluntary subscriptions or local funding. His conception of the size and scale of the institution that would be required in the immediate future was effected by a combination of several factors. These factors made his position different from that of other managers at the end of the previous century. Planning and policy was grounded in evidence that pointed to a large, and expanding, number of defectives that required .specialised services. An infrastructure had also emerged that linked institutions around the country with central government, and the development of national policies. Both policy and provision had started to address the prospect of long-term care as well as education and training. The combination of these factors discouraged Burden from thinking about small institutions. The prospect of a long-term commitment from the government, and the presence of a large number of people that had been identified as potential users of a residential service, encouraged him to plan on a large scale. A large institution would enable him to reap the benefits from economies of scale. Any savings that were made would be offset against regular expenditure on maintenance so that costs per bed could be kept to a minimum.

The creation of a national, integrated strategy that included education, as well as accommodation and permanent care for adults, would allow more cost-effective management of welfare services. Thomson (1998, p.32) has pointed

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[45] Roy. Com. Feeb., II, p.231
[46] Roy. Com. Feeb., VIII, p.511

out that in addition to the categories for placing people under care the new system also facilitated "the removal of idiots, imbeciles, the senile and other groups from lunatic asylums so that they could be rescued from being sites for permanent care and returned to their intended role as curative hospitals". The development of institutions like Stoke Park, which were specifically for mental defectives, was in keeping with a more widespread reformation of the welfare system. The movement towards greater economy and efficiency was expedited by reinforcing the "curing" and "caring" functions of different services. While Stoke Park offered training the designated function of the colony was to provide permanent care. The skills that the inmates were taught contributed to the economy and efficiency of the institution by reducing day-to-day expenditure on food, clothing and laundry. This was not a new development; from the late seventeenth century onwards workhouses had privileged idiots above lunatics because of the utility of their labour (Andrews, 1996).

Harold Burden rented the Stoke Park estate in July 1908, on a 21-year lease, at an annual rent of £150. When the school opened in 1909 a part of the main house was used to accommodate girls, while boys used the old stable block, renamed Ivy Lodge. Although the school began with a small intake of 150 the buildings offered plenty of scope for expansion, and the estate comprised 100 acres of land that offered the inmates opportunities to work in the gardens or on the farm. In addition to the accommodation that was available on site there were staff employed to train the children in laundry, housework, weaving, gardening, carpentry, boot-making, tailoring, brush making, and farm work. The colony aimed to provide resources and a level of supervision that would enable the inmates to "do their own housework, make their own clothes and boots, grow their own farm produce, and contribute towards the cost of their own maintenance by simple industries generally"[47]. The brochure also made specific reference to the Hospital Block that provided "Open Air treatment" for weak children:

> The Hospital is specially intended to meet the needs of children sent

[47] BRO 40686/PM/8(b) p.4

> to the Colony whose feeble physical condition makes it appear that special provision is desirable. ... The large windows are made in sections, and can be partially lifted or wholly removed at pleasure. The parts of the building completed and in occupation provide two small wards, Nurses' duty rooms, bath and lavatory accommodation for patients, Matron's and Nursing Staff day sleeping apartments, bathrooms, lavatories and offices.[48]

The Commissioners for Reformatories and Industrial Schools also mentioned the hospital block in their report of 1911. It was described as being equipped with 55 beds, but the building was being extended to provide space for an additional 100 beds. The report stated that:

> This is an excellent part of the institutions, well adapted to its purposes. It possesses, in addition to ordinary wards, an extensive open-air veranda overlooking the park. Five double-bedded revolving shelters are also attached to the hospital for summer use. Taken as a whole the hospital contains the best accommodation for its purposes that has been seen for some time, and is equipped up to a modern standard in all respects.[49]

While the Colony was expanding it was also diversifying and providing more specialised services. In addition to providing education and training it was also able to offer weak or sick children a hospital service (with a visiting medical officer) on site.

Developing the hospital, and in particular the facilities for "Open-Air treatment", ensured that for many years Stoke Park was used as the main colony for inmates with tuberculosis and other conditions that required similar treatment. Thomson (1998, p.116) has suggested that the development of tuberculosis colonies provided a useful analogy for the shift from asylums to colonies. Treatment for tuberculosis began with confinement in sanitoria to stop the spread of infection to the healthy population, and to facilitate an infected individual's recovery. When it was discovered that patients discharged from the

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[48] BRO 40686/PM/8(b) p.27

[49] CRIS Annual Report 1911, p.247

colonies relapsed when they returned to the community a "hardening up" programme became part of the treatment regime so that they were prepared for life outside by undertaking light work. It was established that this strategy had not been effective when discharged patients had been observed to go through a cycle of returning to unhealthy industrial environments to secure employment, relapsing, becoming unemployed and renewing the risk of the spread of infection.

Colonies were proposed as a solution to the recurrent problem of relapse and infection control. Families would be encouraged to remain in the colony after treatment where they would benefit from sheltered accommodation, the company of other people who had shared their experience of illness, and the availability of suitable work on site. The proposal was seen as humanitarian and hygienic. From a eugenic perspective "any hereditary predisposition to tuberculosis would be contained within the colony" (Thomson 1998, p.117). The colony at Stoke Park did not deliver a single service to a single group of users. It provided a hospital, treatment for people with tuberculosis, a school, and accommodation for a mixed population. The site focused a range of services and resources within a restricted geographical area. This enabled the Burdens to capitalise on the land and buildings they leased, as well as containing and segregating the inmates from the rest of the population. The additional investment in the Hospital Block suggests that the Colony had started to develop specialised resources that would secure its long-term interests in a welfare system where different organisations and agencies were providing similar accommodation and services.

The report from the Commissioners for Industrial Schools in 1911 also referred to an increase in the number of staff on site. The total number of staff had risen from 48 to 59 comprising:

> Controller Capt. Knowles, visiting medical officer Dr Ambrose, visiting chaplain the Vicar of Stapleton, 4 matrons, 6 fully trained hospital nurses, 2 kitchen mistresses with 2 assistants, 1 laundry mistress with 2 assistants, 4 charge attendants, 2 trade instructors, 6 nurse attendant teachers, 20 ordinary nurse attendants, 1 engineer, 1 head

gardener with 2 assistant gardeners, 2 stokers and 1 labourer.[50]

Unlike the previous report it did not make any specific reference to the number of certified teachers on the staff. It has amalgamated a large group of people under the generic term "nurses" including trained hospital nurses, nurse attendant teachers, and nurse attendants. The increase in the number of nursing and teaching staff on site indicated the extent of their involvement in the day-to-day management of activities. Physicians were more detached from the routine aspects of daily care. Responsibility for the multitude of small tasks that enabled inmates to move between activities, from one part of the day to another, and from one day to the next, were devolved to those members of staff whose personal contact with the inmates was greater than that of the physician. Within the colony a disparate group that incorporated trained nurses and teachers, housekeepers, gardeners, and a large contingent of unqualified, untrained staff supplied the labour that was required to "look after" and supervise inmates on an hour-by-hour basis. The group that has been described as "nurse attendants" constituted the largest single group of staff within the institution. Scull (1993, p.263) has stated that attendants working in psychiatric institutions were recruited from the "dregs of society". The combination of low status and low pay meant that it was difficult to recruit and retain high caliber staff. While there is no evidence to suggest that the staff at Stoke Park were drawn from the "dregs" of society the work carried out by the attendants was not well paid, nor was it regarded as prestigious or "skilled".

The growth of Stoke Park Colony was indicative of a second wave of institutional development that followed the establishment of the large charitable asylums. In 1905 the largest of the institutions, the Royal Albert held 606 residents, the second largest, the Earlswood Asylum, held 495, the Western Counties held 272, the Eastern Counties held 256 and the Midland Counties held 272 giving a combined total of 1901 residents. The M.A.B. provided places for 1000 patients at Darenth Asylum, and similar numbers at Caterham and Leavesden (figures cited in Thomson 1998, p.12). Although the school at Stoke

[50] CRIS Annual Report 1911, p.247

Park began with a small intake of 150 residents in 1909 it grew rapidly so that by 1916 it was the largest institution providing a total 1268 places.

Between the first and second waves of institutional development the philosophies, ideologies and practices that shaped the delivery of services for mental defectives had changed so that the role and function of institutions had been transformed. By the end of the century the charitable asylums were attempting to curtail provision for chronic cases by adapting their admissions policies so that they became training institutions for the feeble-minded. If they were to continue to supply the same services that they had provided hitherto they had to become more selective. Parents were discouraged from sending their severely disabled children and encouraged to use the asylums for their handicapped but "educable" children. One of the factors that contributed to the rapid growth of Stoke Park was the willingness of managers to deviate from this practice and provide accommodation for both "educable and uneducable" residents. This meant that Stoke Park was admitting residents from a broader range of applicants instead of competing with other institutions for the most able applicants. At the same time the view that institutions should provide permanent, segregated care had taken precedence over the view that training could ameliorate the impact of mental deficiency. While the Board of Control were willing to commend the managers at Stoke Park for extending their services to more disabled residents the promulgation of views on permanent care had reduced the likelihood that people could move away from institutional care into alternative forms of provision in the community.

Exploration of the micropolitics that connected Harold Burden with the permanent officials in the Home Office, and the other members of the Royal Commission on the Care and Control of the Feeble Minded, has pointed to his ability to manipulate knowledge of policy developments on a national scale, and information pertaining to the local situation, in order to facilitate the development of Stoke Park. Burden was able to transfer the practical experience that he had gained from providing cheap accommodation for inebriates to providing low cost provision for mental defectives. The rapid development of the site from a school

to a colony indicated his capacity to interpret the political climate surrounding mental deficiency and anticipate the direction that policy would follow. Burden developed a role and function for Stoke Park that were congruent with the ideology expressed in national policies. The development of the resources on site were not indicative of a small, localized charitable organization, Stoke Park became a prototypical colony. The managers had responded to the demands for a specialized service in the years leading up to 1916 by creating provision that resembled "the modern institution" described in the Wood Report (Interdepartmental Committee on Mental Deficiency 1929, p.22):

> The modern institution is generally a large one, preferably built on a colony plan, takes defectives of all grades of defect and all ages. All, of course, are properly classified according to their mental capacity and age. The Local Mental Deficiency Authority has to provide for all grades of defect, all types of care and all ages, and an institution that cannot or will not, take this case for one reason and that case for another is of no use to the Authority. An institution which takes all types of ages is economical because the high-grade patients do the work and make everything necessary, not only for themselves, but also for the lower grade.

Stoke Park had developed an admissions policy that admitted people of "all grades of defect and all ages." It had also established an economy that relied on a degree of self-sufficiency. The skills that were taught within the institution were used to reduce its running costs instead of providing the inmates with the means to earn an independent income. The tenor of the Wood Report denotes a significant change in the relationship between the Mental Deficiency Committee, local authorities and the managers of institutions. While the Board of Control were prepared to commend the "public spirited" attitude of the managers of Stoke Park in their Report from 1916 the phraseology of Wood Report is more prescriptive. It suggests that Harold Burden had been correct when he anticipated that policy decisions made at a national level would define the role of institutions in the future, rather than decisions made by the management at a local level. Policy was initiated through the work of a national committee and then disseminated through the Local Mental Deficiency

Authority. While the managers of institutions had some leeway to interpret policies to suit local conditions and resources the power they exercised was circumscribed by their capacity to remain "useful" to the Authority. The system of administration, regulation and monitoring that was implemented through the Mental Deficiency Committee and the Local Authorities corresponded to the system that Norah Fry described in the statement that she submitted to the Royal Commission[51]. She had envisaged a system where the emphasis would change from a voluntary effort supplemented by the State to a system where the onus for the provision of services would reside with the State, supplemented by voluntary effort. As the number of people effected by legislation pertaining to mental deficiency increased, and the directives from the Mental Deficiency Committee either encouraged, or compelled, them to admit defectives from all grades the potential for small, selective voluntary institutions diminished.

Resources and Responsibilities

Appointing the Royal Commission was a governmental response to the anxieties and concerns that had been exchanged among the educated classes. Although doctors and educationalists were included in the membership lay members dominated the Commission. Members like Ellen Pinsent, Charles Loch, W.H. Dickinson and the Reverend H.N. Burden came to the Commission with a prior commitment to extending care beyond school age (Thomson 1998, p.24). The evidence that the Commission produced, and the conclusions that were derived from it, capitalised on the value of practical experience. Harold and Katherine Mary Burden, the founders of Stoke Park, had already established a reputation through their missionary work and their work with inebriates. Between 1902 and 1904 they had established over 450 places for inebriates. By 1907 they controlled 617 licensed places under the National Institutions for Inebriates (Carpenter 1996, p.206). When he joined the Commission Harold Burden was able to contribute the skills that he had gained from his experience as a manager and offer the Government a firm commitment

[51] Roy. Com. Feeb., II, p.231

to economy. A memorandum that he attached to the Commission's report in 1908 stated:

> I am in complete agreement with the report as a whole. But I should like to give prominence to the need for economy in and strict Governmental control over the establishment of institutions for the reception of mentally defective persons.
>
> I am of the opinion that the cost of building an institution for the mentally defective (other than for persons of unsound mind) should never exceed £150 a bed, and for many of the classes of the mentally defective suitable provision can be made at a cost not exceeding £100 a bed. [52]

He managed to combine a reputation for philanthropic activity with careful management of resources. His final comment regarding the possibility of reducing costs for some classes of inmates from £150 to £100 suggests that he had an eye on the profit that could be derived from the labour of some of the more able residents.

Between 1909 and 1920 Stoke Park expanded and more properties were added to the group. The expansion was necessary to accommodate successively larger numbers of inmates. Developing the site was indicative of the stability that followed the successful implementation of the colony model. When the School opened work had been in progress to upgrade the existing facilities. To accommodate the boys alterations had been made to the stables so that they could be used as a residential block. Construction work for new buildings began in the same year. St. Catherine's buildings were completed in 1910. St Catherine's denoted a substantial increase in the size and scale of the institution:

> The number of rooms is rather more than one hundred, including 22 dormitories and 12 day rooms for inmates, 9 sitting rooms and 30 bedrooms for staff, and 30 service and office rooms. There are 10 baths for inmates, and 3 bathrooms for staff, 25 WC's and washing lavatories for inmates, and 8 for staff...The dormitories have windows on at least two sides, and are of a uniform width of 25 feet and 12 or more in height. In every instance they are overlooked by a room provided for the use of a nurse attendant. The ordinary day rooms for

[52] Roy. Com. Feeb., VIII, p.511

> inmates are mostly 26 feet by 25 feet and the corridor day rooms 40 feet by 18 feet. In the South Block there is a Recreation Hall 54 feet by 25 feet, while in the North Block special provision has been made for children requiring close individual care. [53]

The buildings provided accommodation for 275 additional cases. When the Industrial Schools Inspector visited in 1910 the report stated that there were 78 boys present and 211 girls. The colony employed 48 members of staff, to supervise the inmates, including a Controller, four Matrons, three Certified Teachers and other Nurses and Attendants. The report also stated that the new blocks were "economical, having been provided at a cost of about £80.00 per bed"[54]. This price was lower than the £100.00 - 150.00 that Burden had anticipated in 1908.

Economical provision had acquired an additional connotation when it was used in the context of institutions specialising in the care of mental defectives. Comparisons had already been made with institutions that provided specialised care for other groups. Thomson (1998, p.26) mentions that the report produced by the Commission had criticised placing mental defectives in lunatic asylums. The Report stated that:

> We find lunatic asylums crowded with patients who do not require the careful hospital treatment that well-equipped asylums now afford, and who might be treated in many other ways more economically, and as efficiently.

Descriptions of Harold Burden's financial dealings from his colleagues and associates provide contradictory images of his personality, motives and income. ~ A description of the work of the National Institutions for Inebriates from a report written by Dr R W Branthwaite[55] in 1906 stated that:

> Although at present one can say but little, it is only fair to point out that any advances made in this direction (Classification) have been

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[53] BRO 40686/PM/8(b) p.18

[54] CRIS Annual Report 1910, p.226

[55] Dr RW Branthwaite was a Home Office Inspector under the Inebriates Acts (*Roy. Com. Feeb., I, p.VIII*).

> very largely due to the Reverend H N Burden and his co-workers, who acting together control the management of those Reformatories which constitute "The National Institutions for Inebriates". Some day, when favorable opportunity offers, and when the modesty of present objecting persons can be overruled, the story of the work of these institutions will reveal a romantic history of energy and self sacrifice which has rarely been excelled[56].

The correspondence file containing material pertaining to the creation of the NIPCC provides evidence of Burden's strong links with some of the permanent officials in the Home Office. Both Branthwaite and W. P. Byrne[57] presented his activities as philanthropic and altruistic. A memorandum from Branthwaite to the Home Secretary from 1910 stated:

> The only other point I desire to mention has regard to Mr. Burden's bona fides. Judged from usual standards the whole scheme seems quixotically generous; so much so that, if one did not know the man, the natural question would seem to be "where does he come in". I have asked the question myself many times during my association with him, with the result that I have failed utterly to find him "come in" anywhere. He has given many years strenuous work, and much money, to the development of what he has originated, solely because he believed it to be his duty to use his money for the benefit of others and because he "had it in him" to do it.[58]

In a memorandum to the Secretary of State Byrne accentuated Burden's dedication to public service:

> Mr. Burden has devoted large sums of money and infinite thought and labour to the carrying out of the work for inebriates and the feebleminded to which he has given his life. It is his wish and hope that he may eventually see his institutions incorporated by Royal Charter, so that they may endure permanently for the public benefit.[59]

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[56] IOR Annual Report 1906, p.19

[57] W. P. Byrne was the first Commissioner of the Board of Control. Byrne was a civil servant. His appointment reflected his capacity for problem solving rather than any personal interest or expertise in the field. He also had strong links with the Central Association for the Care of Mental Defectives that became the Central Association for Mental Welfare after 1921. See M. Thomson *The Problem of Mental Deficiency Eugenics, Democracy and Social Control, c.1870-1959* (Oxford, 1988), 99, 153.

[58] PRO HO 45/196606/1A, Memorandum by Branthwaite October 5, 1910

[59] PRO HO 45/196606/3

An annotation to the memorandum stated:

> This is unusual but I think it may be done. Mr. Burden has devoted his fortune to useful public purposes in which the Home Office is specially concerned, and if the Secretary of State undertakes the duties which would be imposed on him by this trust deed, he will be promoting these purposes, as well as paying Mr. Burden a compliment which he well deserves. [60]

A record of a meeting that took place in 1909 between Dr. Newman, from the Education Board, and Mr. Burden presents a different image of Burden. The meeting occurred because of a disagreement between Mr. Burden and Mrs. Ellen Pinsent regarding the management of Sandwell Hall. When Dr. Newman stated that the public should exercise some control over the management of the institution because a significant proportion of its income had been derived from public sources it was reported that:

> Mr. Burden claimed to have expended £10 000 as capital outlay (at Sandwell), expecting to obtain three and a half %, and that, above and beyond this, he receives nothing. Indeed he says that there is a deficit on the working, which apparently, he stands to lose.... [61]

When Dr. Newman congratulated him on possessing great wealth and his willingness to devote a proportion of it to the welfare of poor children, "con amore", Mr. Burden would not accept any congratulations and denied being a philanthropist. Dr. Newman wrote that:

> My rejoinder was that if he did not do all of these things for the love of the thing, he did it as business and to make a profit. This he denied. I then said to him "Then what is your motive, if it is neither love on the one hand nor business on the other? To this there was no satisfactory answer.[62]

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[60] PRO HO 45/196606/3

[61] PRO ED 32/187 (50764) 20619B 22, Memorandum from G. Newman to the Board of Education October, 1909

[62] PRO ED 32/187 (50764) 20619B 22, Memorandum from G. Newman to the Board of Education

Mr. Burden's reluctance to respond to questions regarding the management, or financing, of the institutions that he was involved with was remarked on by other people that conducted business with him. The lack of evidence pertaining to his financial dealings, and the puzzlement that was expressed by individuals who attempted to extract information from him, suggest that he considered any investigations into his conduct an intrusion. Although there is nothing to suggest that he was attempting to conceal impropriety, there is evidence to suggest that he did not wish to make the financial side of his operations visible. To establish an impression of the situation at Stoke Park it has been necessary to supplement the existing material with evidence from his work in other places, and from different periods in his life. As a result of this some of the material relating to resources and responsibilities at Stoke Park rests on an assumption that he used the experience that he gained form his other ventures and organizations to guide him at the Colony. There is also an underlying assumption that the reports of his personality, temperament and motives that other people have provided describe characteristics that remained consistent throughout his life.

The evidence that is available points to a dramatic change in his fortune. In 1886 he was declared bankrupt as a grazier, stockdealer and dairyman. His biography states that he lived as a poor man at Cambridge and people assumed that the College Authorities had found posts for him so that he could help to pay his way. Despite a lack of visible wealth during the early part of his life, his involvement with the National Institutions for Inebriates and the NIPRCC enabled him to build a fortune. When he reached his forties he was in a position to make substantial property acquisitions. In July 1926 Harold and Gladys Burden (Harold Burden's second wife) consolidated their existing property. They created a Private Limited Company entitled Great Stoke Estates Ltd. incorporated on 17 July 1926, with a nominal capital of £10 000 to acquire

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October, 1909

property[63]. On the 15 December 1926 Harold Burden formally transferred property that he had purchased at Purdown (The Elms) and Whittington Hall to the NIPRCC Trustees (himself and Gladys Burden). At the same time he transferred his other land holdings to the Great Stoke Estates comprising the Whittington Hall estate and surrounding farms, Abbots Leigh estate and surrounding lands, Clevedon Hall, land and farms around Stoke Park and Stapleton Park (Beech House) and a field in Hanham. In total the land holding was over 1500 acres. In 1927 Great Stoke Estates proceeded to buy more land including the freehold of Hanham Hall and other lands totaling 196 acres, Heath House in 1928, and The Worthies at Purdown in 1929. After the death of Harold Burden Great Stoke Estates purchased the park of Stoke Park and some houses in Clevedon. When it was liquidated in 1933 by Mrs. Burden, Great Stoke Estates owned over 2000 acres[64]. The Times (July 1930) stated that his estate was valued at £149, 161 gross, £144, 834 personally.

Although Harold Burden had declared in a memorandum of 1908 that he appreciated the need for "strict governmental control"[65] he appeared to resent any interference from other people. His preference for working with a few of the permanent officials from the Home Office may have been an attempt to limit access to a few, selected individuals that he was familiar with, rather than exposing the management of the Institutions to more pervasive public scrutiny. A contributory factor to the conflict between Ellen Pinsent and Mr. Burden had been a disagreement about the role of the management committee at Sandwell Hall. It appears that Mr. Burden fell out with the committee and gave notice to close the institution. The investigation conducted by the education department recorded that Mrs. Pinsent catalogued a number of complaints that referred to a shortage of resources, failure to respond to the orders of the Visiting Medical Officer, poor organization and the "unsuitability" of one of the members of staff that Mr. Burden had appointed[66]. Mrs. Pinsent told Mr. Burden that she would

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[63] 1930 Deed of Appointment of Field as Trustee of NIPRCC – in possession of the Trustees of Burden Trust. The original 1926 deed is missing.
[64] Cited in the deed of voluntary liquidation of Great Stoke Estates Ltd. 12 April 1933. Copy held at Bevan Ashfords Solicitors, Bristol.
[65] Roy. Com. Feeb., VIII, p.511
[66] PRO ED 32/187 (50764), Statement compiled from notes made by E. Pinsent, October 7, 1909.

resign from her position as Honorary Secretary unless a first rate Matron and Head Teacher were appointed. She also made a request for the establishment of a house committee that would meet monthly to address some of the issues that had been outlined in her complaints. The Committee met in January 1909 but came to loggerheads with the Burdens in June. The Burdens claimed that the Committee was maintaining an attitude that made Mr. Burden's position as Warden untenable. He claimed that he would have to close the institution because he felt that the Committee has brought him "to limits which can not be exceeded without loss of self respect"[67]. The Committee had objected to the transfer of some inmates from Sandwell to Stoke Park but money seems to have been a significant factor in the conflict. An explanatory letter written by Mr. Burden stated:

> Someone intimately connected with the Institution is most industriously circulating a report that we get our living out of Sandwell. Not one penny of the money we have spent on the institution has come back to us, neither have we received any interest there on.[68]

The House Committee resigned saying that they could not work with Mr. Burden because he did not attend the meetings. On October 4 1909 he visited members of the Board of Education to discuss the situation. Dr. Newman, one of the members of the Board who had not met Mr. Burden before, recorded this impression of him. Mrs. Pinsent's tale seemed to:

> be an under-estimate, rather than an exaggeration of various troubles and difficulties that she has had to meet.

When people made complaints:

> Mr. Burden seemed unable or unwilling to meet them, and very frequently alleged that such and such a matter would require a further outlay of money and, therefore, came under his control and

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[67] PRO ED 32/187 – 18839B. Explanatory letter from the Burdens 27 September, 1909

[68] PRO ED 32/187 – 18839B. Explanatory letter from the Burdens 27 September, 1909

not theirs ...[69]

In addition he noted that some of Mr. Burden's correspondence with the Board of Education indicated a rising level of irritability. At one point Dr. Newman wrote that Mr. Burden had stated that he was getting tired of the Board and its "domineering insolence"[70].

Dr. Newman's account does not accord with the glowing reports produced by the Industrial School Commissioner or the Royal Commission. The report from the Commission in 1908 had stated that Sandwell Hall was one of six homes where the principle of permanent care had been most "absolutely and adequately accepted"[71]. Following the resignation of the House Committee the Local Government Board had not given sanction to the sending of children by the Board of Guardians to Sandwell Hall but the lack of alternative placements meant that the Board had to reconsider its actions. Because the provision of residential accommodation relied on initiatives from the private sector the Board could not afford to loose it, or appear to be disparaging towards the enterprise. Simmons (1978, p.399/400) has noted that the first Report of the Board of Control commented on the unwillingness of local authorities to build mental defective institutions. While local authorities were reluctant to invest resources in institutions it was unlikely that private initiatives such as those at Sandwell or Stoke Park, where Burden had covered the initial costs, would not be cast in a bad light if it could be avoided in case it discouraged further investment from the private and voluntary sectors. Dr Newman recommended that Sandwell Hall could be re-certified provided that a Committee of Managers was appointed, that Mr. Burden should not be Honorary Secretary, and that the Committee would be allocated control of expenditure on maintenance. Included in the rules that were established to allow the Board of education to continue to certify the

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[69] PRO ED 32/187 (50764) 20619B 22, Memorandum from G. Newman to the Board of Education October, 1909

[70] PRO ED 32/187 (50764) 20619B 22, Memorandum from G. Newman to the Board of Education October 7, 1909

[71] Roy. Com. Feeb., VIII, p.511

place was a rent charge for the founders[72]. This device was used in the constitution of the NIPRCC to provide a regular source of income:

> A nominal charge of 1/- is paid by the Incorporation to the trustees for the Institution property but economic rents are paid for the lands used for farming and for the houses occupied by some of the staff only. Up to the date of the death of the Rev. Burden these payments were used by the trustees not only to maintain and develop the properties, to provide central offices, and maintain free cases, but also to repay H.N. Burden & K.M. Burden amounts expended by them on the institutions.[73]

In addition to income derived from this source the first Trust deed required that a special rent charge be levied for the inmates:

> A rent charge equivalent to the annual value of the hereditaments calculated at the daily rate of three pence per unit of accommodation or alternatively three pence per bed less any rent paid under covenant contained in leases (on property) shall be charged to the common funds of the Institutions and shall be described in the accounts of the Institutions as "Rent Charge"... On the present Warden ceasing to hold the office of Warden the rent charge shall ... in common with all other accounts be administered by the Trustees who may (and shall if the Founders, or surviving Founder ... shall so require) ... apply the moneys for payments in consideration of the Establishments of the Institutions and in reimbursement of money expended in acquisition of and works upon the trust premises.[74]

The combined income from the 2,000 licensed places was over £9,000 a year. Between the creation of the NIPRCC as a Trust and the death of the Reverend Burden this income amounted to £134 000, less lease rents. Although money from rents was used to maintain and acquire property many of the acquisitions only took place after the rents had raised enough money to fund the purchase. Nearly all of the properties had been leased prior to purchase with an option to buy at a fixed price. This was the pattern at Stoke Park that had initially been leased from the Beauforts, and was subsequently purchased from them in

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[72] PRO ED 32/187, Memorandum dated March 10, 1910

[73] BRO Instruction to Counsel for the Trustees of the NIPRCC, 1947. In Trustees collection. Uncatalogued.

[74] BRO 39910/B/a-b, p.8

1917.

Evidence suggests that Burden, and some of the contacts that he had in the Home Office, were aware of criticism being leveled at the management of the NIPRCC. Correspondence relating to the establishment of a limited company to manage the Colonies stated that:

> Mr. Burden called on Friday and asked if the Home Office would assist him to obtain a license under section 20 of the Companies Act. He was taking this step partly because he thought the public took an unfavourable view of privately managed institutions and partly because he has been given to understand that the regulations under the Mental Deficiency Act would be less stringent for institutions provided by a company. [75]

The origin of the "unfavourable view of privately managed institutions" was not explored but conflict between managers and the bodies responsible for allocating public funds, such as the disagreement between Ellen Pinsent, the House Committee and Burden over the running of Sandwell Hall, may have been a contributory factor. Burden's style of management had attracted specific criticism. In his memorandum to the Home Secretary Branthwaite noted that Burden had been attacked from "many quarters" for running a "one man show"[76]. In spite of this the Trust deeds, and Burden's conduct, served to consolidate his power. The deed declared that the various properties leased or owned for purposes of the NIPRCC were held by the Burdens, and their heirs on the Trusts declared in the deed. The Burdens could appoint two more trustees, so could the Home Secretary, but this was never implemented. The Burdens remained the only trustees until Harold's death, when appointments started to be made. The deed also recognized Harold Burden as Warden until he chose to resign or died. The position of Warden allowed him to:

> continue to administer all the affairs of the Institutions with the same freedom from interference as he had done from their foundation [77]

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[75] PRO HO 45/196606/5

[76] PRO HO 45/196606/1A, Memorandum by Branthwaite October 5, 1910

[77] BRO Home Office letter reference 196606/4 reproduced in Declaration of Trusts. Uncatalogued

Burden's reputation as "the most excellent and economical of managers"[78] has two different dimensions. Evidence from different enterprises has demonstrated that he consistently used his managerial skills to provide resources at the lowest cost. While he worked as a curate, and then a vicar, in Canada he reported that he built four substantial churches, and two parsonages at astonishingly "small a cost" (Burden 1894, p.68, p.111) which he left completely free from debt. Similarly the reports on his reformatories for inebriates recorded that his management of resources made a favorable impression. Branthwaite's report on reformatories from 1906 stated that the capital costs of the beds in the National Institutions homes were the lowest in the country[79]. The costs varied between £100 and £200 per bed while all of the other institutions had capital costs in excess of £400 per bed. The National Institutions and Brentry also had the lowest weekly cost per inmate in 1907. The strategies that he used to create savings and contain costs were not documented, although the low costs of the inebriate institutions were partly due to low staff costs and high incomes from inmate activities. Ellen Pinsent's views on the resources that were available at Sandwell Hall present a different perspective. Mr. Burden had claimed that he would see that all was prepared for the new arrivals. She stated that she was surprised to find that at the time of opening the Institution "was not sufficiently equipped to receive inmates". During the first year she listed a number of areas where difficulties had arisen:

1) There were not sufficient clothes.
2) The clothes in which the children arrived were sometimes worn indiscriminately by other children...
5) There were not sufficient drinking cups, or knives or forks ...
8) There were no proper arrangements for cleansing new admissions; the orders of the Visiting Medical Officer were not carried out.
9) There was not sufficient furniture for the Staff.
10) The children in the Institution became very verminous. Even children who came from other Institutions as were almost

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[78] PRO ED 32/187 (50764), Statement compiled from notes made by E. Pinsent, October 7, 1909
[79] IOR Annual Report 1906, p.27

certainly clean on admission, were found to have sore heads from admission ... (On a survey I) found about 14 girls in such a condition that it was necessary to crop their hair short. There were only a few girls whose heads were quite free from nits.

11) Escapes ... in my opinion many that took place from Sandwell were the result of poor organisation. The Officers had no rules or timetables given them, and when I asked for them, I was told that it was not Mr. Burden's custom to provide them in his Institutions. I obtained leave to draft them, and submitted them to Mr. and Mrs. Burden in London, when they were approved and sent to Sandwell, but the Matron did not see that they were carried into effect. There were constant changes in the Staff, and I do not think the rules were given to new Officers. Children were often left alone because one Officer went off duty before the relieving Officer appeared.[80]

The complaints suggest that the resources that had been provided were barely adequate. Economy and efficiency may have been gained by cutting costs on basic materials like cutlery and clothing. Similarly Burden's selection of employees may have been guided by their capacity to save money rather than their aptitude for working with children. Pinsent's statement went on to describe how Mr. Burden had replaced the first matron with Mrs. Upfold, an officer from one of his inebriate reformatories. Pinsent describes her as a rough and uneducated woman with a "very hasty temper". Pinsent reported that she punished inmates that had wet their beds by allowing the smaller children to pull up the nightgowns of the bigger ones and slap them. When she pressed for Upfold's dismissal Burden resisted and told her "she was a very valuable officer, and saved him £200 a year by her economy"[81].

Conclusion

This chapter has examined a range of factors that led to the expansion of Stoke Park Colony for Mental Defectives. Unlike some of the smaller private institutions that had opened during the nineteenth century the NIPRCC set out to combine training with permanent, custodial care. A significant amount of the

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[80] PRO ED 32/187 (50764), Statement compiled from notes made by E. Pinsent, October 7, 1909

development at Stoke Park occurred before the implementation of the 1913 Mental Deficiency Act. Stoke Park became a prototypical colony providing accommodation for both "high" and "low" grade "defectives". The colony model facilitated the segregation and seclusion of mental defectives as well as providing opportunities to save money through economies of scale. Material from the Royal Commission has been used to show that Stoke Park grew at a time when the dynamic of the mixed economy was changing. Increased demand for specialised services necessitated strategic planning. Although various models for the provision of services had been presented to the Commission Harold Burden managed to secure resources for developing the site by combining private ownership with a firm commitment to economy, and his avowed willingness to submit to strict governmental control.

While Burden's ability to control costs and provide cheap accommodation attracted praise from the Home Office evidence presented in this chapter has shown another side to his character that was not consistent with his reputation for altruism and philanthropy. In his appraisal of Burden's work with "inebriates" and "mental defectives" Carpenter (2000, p.63) has explored conflicting impressions of Burden's character and motivation. Material in this chapter has referred to his parsimony and his alleged tolerance for draconian behaviour on occasions when it permitted the NIPRCC to save money. Descriptions of Burden's relationship with the Home Office, and descriptions from staff working in other institutions that he managed, have indicated some of the tensions that are likely to emerge in partnerships that bring together public and private initiatives. Burden's acquisitions of property, land, and a substantial personal fortune have provided a stark contrast with Ellen Pinsent's comments on the impoverished conditions at Sandwell Hall. Similarly his positive relations within the upper echelons of the Home Office were not consistent with his behaviour towards local committees. While he professed a willingness to submit to strict governmental control he appeared to resent any interventions in his affairs at a local level. The manner in which he dismissed attempts to examine the management of the institutions as external interference is comparable with

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[81] PRO ED 32/187 (50764), Statement compiled from notes made by E. Pinsent, October 7, 1909

complaints from private and voluntary providers in the twenty first century who complain about the "red tape" and "bureaucratic control" imposed on them by local authorities.

Chapter 3 will examine the research methods that have been used to gather material for Chapters 1 and 2. The chapter will also discuss how interviews and techniques derived from phenomenology and ethnography were used to develop material in the later chapters.

Chapter 3

Methodology

This chapter will discuss research methods, sources of evidence, and how they have been used in this study. Chapters 1 and 2 looked at the investment of public and private funds in specialised services for people with learning disabilities from the middle of the nineteenth century. Subsequent chapters will present comparative analysis of past and present services. The combination of historical material with contemporary evidence has shown that the past can exert a powerful influence over the present. This influence may be reflected in the perseverance of existing ideas, or conspicuous attempts to avoid replicating solutions that have been tried before. Using this approach the researcher has had an opportunity to critically discuss the present in terms of a link with the past, and the future. Jackson (2000) has made an analogy between taking a personal history in order to gain a better understanding of an individual's health or educational ability, and studying the past in order to understand aspects of the present:

> Just as the current health, illness or educational ability of a person possesses its own historical roots, so too the structures, ailments and strengths of modern welfare and educational systems can be seen as the product of past and present processes.
> (Jackson 2000, p.45)

He goes on to say that the benefits derived from studying history go beyond a better understanding of events that have already taken place. They also provide historians with materials that will enable them to make recommendations about the direction that services could take in the future:

> Similarly, modern scientific knowledge, including the production of medical and educational categories, as well as the creation of novel medical and pedagogic strategies, has been fashioned by intellectual, political and cultural factors operating through time. If we are to understand, manipulate and improve our present and future health care and education services, then we need to analyse the historical evolution of those services.
> (Jackson 2000, p.45)

Data used in this research has been derived from a variety of sources. Using materials from different sources has allowed the researcher to compare and contrast the views of different individuals and groups as well as historical data from different eras. The use of "reflexive interviewing" (Hammersley and Atkinson 1955, p.152) allowed interviewees to produce a record of their thoughts, beliefs and feelings using their own words and minimal guidance from the interviewer. A flexible approach was most likely to provide valid data. Reliability (i.e. consistent use of prompts and questions) was maintained by focusing each interviewee on specific topics and issues (a list of typical questions and prompts has been included in Appendix 1). Documentary sources have been used to provide details of events that interviewees were not able to recall (because they had not been present when the event occurred, or because it had happened a long time ago). Documentary evidence in this research includes evidence that has been derived from reports, publicity material and parliamentary papers. Television interviews with hospital staff and residents have also been used, along with reports from local and national newspapers. The types of evidence used in this study and the research methods have been summarised in Appendix 2.

Smelser (1994, p.46) has identified four stages in the typical sociological research process that enables the researcher to move from identifying characteristics of the research population towards final results. These stages are:

1 the choice of descriptive variables to characterise each of the individuals in the population examined;
2 the choice of individuals who constitute that population;
3 the coding (or recoding) of the initial data gathered and appropriately described and, when applicable, the mode of data collection;
4 the methods of analysis employed to treat the data so that formal, often statistical, results can be furnished.

Smelser has described how research moves towards a final result by going through stages that involve the selection of a sample, collecting and coding data, and then analysis. In the context of this research movement into the initial stages of the process was dominated by the researcher's consideration of two major issues. The first issue was the relationship of the researcher to the services under examination. This involved reflection on my previous experience as an employee

within the services, and the ways in which this experience could influence the design and implementation of the research. I also had to consider whether my previous experience would be perceived as an obstacle when I sought access to staff within an NHS Trust, and when I sought approval from the local Research and Ethics Committee (a copy of the "Application for Approval" form and covering letter has been included in Appendix 3). My previous experience was not perceived as an obstacle because I had not worked at Stoke Park (except as a Tutor), therefore I had not accumulated any "prior knowledge" of the interviewees that was likely to influence the selection of a research sample. Although my nursing background was likely to create the context in which I interpreted data (e.g. a preference for certain conceptual schemes) I was convinced that it was acceptable to proceed by literature that suggested it was not plausible (or desirable) to erase the identity of the researcher from the account of the research. Gouldner (1962) and Phillips (1971) have described the importance of acknowledging the researcher's own values and experience. Similarly Hammersley and Atkinson (1995) have encouraged researchers to show evidence of analytic reflection in their writing. This has led to the inclusion of biographical information in this chapter and the identification of details from the researcher's background that were likely to have had direct bearing on the progress of the research.

The second consideration was the design of a research method and tools that would produce credible results. Development of the design and tools was guided by an examination of two sociological schools that have facilitated the growth of research in social sciences. These were the school dominated by the positivist tradition and the phenomenological school. Kolakowski (1993, p.7) has described positivism as a "collection of prohibitions" surrounding human knowledge. According to Kolakowski positivism anchors research in observation so that results are seen as more than speculation, and therefore cannot be contradicted by empirical data. To develop a method of investigation that would respond to historical data, and record the impressions of people that were employed in the services, it was necessary to combine elements from different schools. A strict application of positivist principles would have excluded much of

the material derived from interviews. Some of the data derived from these sources was speculative. Respondents were asked to describe their recollections of the services when they first started working. They were also asked to express their opinions about the future of the services, and to contemplate the ways in which services could be improved.

The subjective and impressionistic content of the interviews tended towards the sort of speculation that Kolakowski described. Although the material was qualitatively different from any data that would have satisfied a positivist researcher's criteria it has remained an essential aspect of this study. Predictions about the future, or recollections of the past, do not provide an objective source of information but the respondents' accounts have provided an oral record of their experiences at work. If personal accounts had been used on their own they would not have been substantial, but used in conjunction with other historical data they have added another dimension to the evidence. To avoid the limitations of a single perspective, and to obtain a comprehensive picture of continuity and change in the learning disability services, the subject has been studied from multiple and different perspectives. Analysis of individual accounts has allowed the researcher to examine the ramifications of policies and social change from a personal perspective. The inclusion of data obtained from documents and academic texts has meant that analysis has been able to move between macro and micro levels. In their discussion of ethnography Hammersley and Atkinson (1995, p.237) have suggested that ethnography is "better suited" to research on micro theory. However they also state that it can contribute towards the development of macro theories. Analysis of the content of interviews combined with a broader historical analysis of continuity and change has provided the researcher with an opportunity to exploit the benefits of both macro and micro perspectives.

The first chapter contained material that has accentuated the significance of change on a large scale. This macro approach located services for people with learning disabilities in a wider pattern of events that have made reference to social, political, demographic and economic factors. In this material individual

accounts have not been pivotal. Academic texts were used to establish the validity of events beyond the perceptions, memory and beliefs of single participants in historical events. This sort of data was used to identify some of the social factors that had shaped or altered peoples' perceptions rather than recording first hand experiences. Data gathered from documents has provided an impression of the forces, pressures and beliefs that have been more extensive than the perceptions of any single individual. Similarly in the study of Stoke Park a range of documents were used to provide evidence that does not rely on any single participants' account of events. Scrutiny of administrative records, memoranda, publicity material and annual reports have provided information that moved the material closer to the standards that are required for a positivist investigation. The description of this material also facilitated a style of commentary and a method of analysis that developed strong thematic links with the historical material from the introductory chapters. Records were a source of empirical data that was amenable to observation and classification. Although it was necessary to consider who had produced the documents, and for whom they had been composed, it was also possible to analyse the content of the text and isolate key factors. Identifying and isolating these factors contributed to an understanding of the impact of ideas that have been shared or contested by different groups.

The Use of Documentary Sources

Documentary sources have been used to verify and cross reference information that has impinged on many different aspects of the study. As well as providing quantitative data e.g. the number of people resident at Stoke Park at different times and the number of staff employed to care for them, it has also provided qualitative information about the different ways that various groups of people have conceptualised and characterised the clients they worked with. Comparing and contrasting different types of documentary evidence from different periods in the history of Stoke Park has made it possible to identify those factors which have remained consistent, and those which have been subject to change during its transformation from an industrial school, to a colony, and finally a hospital. In addition to the materials that have been produced by employees, or employees of

other agencies involved in the delivery of services, the study has made reference to materials produced by people and organisations that were not connected with the colony, hospital, health or social services. This material includes television and newspaper reports on the hospital. These materials were not selected because they were perceived as more reliable, objective or valuable than materials produced by people within the services. They have been included because they provide some evidence of the various ways in which people with learning difficulties have been presented to the public through mainstream channels of communication. Analysis of the content and style of reports has provided a record of the social identity of hospital residents, and the process of its construction in different media.

To examine the significance of an individual's role in the delivery of services, and to explore the impact of attitudes, values and beliefs on their work it was necessary to select a research method that allowed the researcher to analyse material that was both subjective and impressionistic. Developing this aspect of the work relied on a phenomenological approach. In the context of this research an understanding of phenomenology and ethnography has allowed the researcher to look at different ways in which qualified and unqualified staff, occupying different positions in the hospital and the community, have perceived events and made sense of what was going on.

Traditions and Postures in Qualitative Research

Up to this point the material in this chapter has focused on the tensions that exist between objective, empirical data and subjective data. Underneath the issues relating to data collection and research methods there was also a more fundamental debate concerning the relationship between the researcher and the services under investigation. This debate is focused on the researcher's experiences working in the learning disability services. The experience that I gained working as a nurse in a long-stay hospital, and the length of my association with the services, has exerted a powerful influence on the way that I conceived this research. The study reflects my interests in learning disability nursing, and the transfer of services between hospitals and the community. A

researcher with a different background may have focussed on another perspective e.g. the impact of community care policies on Community Learning Disability Nurses, or a different occupational group. Smelser (1994, p.46) has pointed out that the assumptions, beliefs and attitudes of the researcher can influence progress at any stage in the research process. They may be influential in the initial stages when the research question is chosen. They may influence the selection of individuals that will be examined, or they can influence analysis by making the researcher accentuate or minimise the impact of some of the findings.

Strong convictions can lead to the adoption of research methods, or the selection of samples that are most likely to corroborate the researchers' own presuppositions. If researchers allow their convictions to shape the data then the coding of the material and analysis will also be determined by the nature of the researchers' beliefs. Gouldner (1962, p.195) has argued that it is fallacious to believe that researcher's can jettison their own values whenever they engage in scientific study:

> That we are in the presence of a group myth, rather than a carefully formulated and well validated belief appropriate to scientists, may be discerned if we ask, just what is it that is believed by those holding sociology to be a value-free discipline? Does the belief in a value free sociology mean that, in fact, sociology is a discipline actually free of values and that it successfully excludes all non-scientific assumptions in selecting, studying and reporting on a problem? Or does it mean that sociology should be so? Clearly, the first is untrue and I know of no one who even holds it possible to exclude completely their non-scientific beliefs from their scientific work; and if this is so, on what grounds can this impossible task be held to be incumbent on sociologists?

Gouldner has argued that research is a social product. The values of the researcher are likely to impinge on the selection, study and reporting on a problem. From this perspective research is moulded and shaped by the perceptions of the researcher so that it could be regarded as a reflection of the researcher's own values rather than evidence of something that exists outside his or her perception. Phillips (1971, p.53) expresses a similar opinion regarding data collection. He maintains that it is "hogwash" for sociologists to claim that they make no assumptions about people and society. He asserts that much of what is

known about human nature has not been derived from empirical evidence. Phillips has gone on to describe how the process of interviewing has been influenced by assumptions about human nature. In the minds of the interviewer, and the person being interviewed, there will be implicit assumptions about the nature of people, or a "model of man" (sic) that will have an impact on the way both parties express their views.

Because of the links between the researcher and the services this study has developed as an "insider account". Developing the study as a piece of ethnographic research, ostensibly conducted by a detached observer, would have involved constructing an alternative identity and assuming the persona of an "outsider". While Gouldner (1962) and Phillips (1971) have maintained that it is difficult for researchers to jettison their personal identities so that they can present themselves as “neutral” or “value free” it still remains incumbent on researchers to identify and discuss those aspects of their personal and professional identities that are likely to have a significant impact on the progress and development of the research, or the interpretation of the research findings. Hammersley and Atkinson (1995) have encouraged ethnographers to address reflexivity in their research and to provide evidence of analytic reflection in their writing. They have stated that the production of research cannot be “insulated from the wider society and from the particular biography of the researcher” (1995, p.16). In their description of research design Hammersley and Atkinson (1995, p.29) have also acknowledged that researchers' understanding of the research problem is shaped by their exposure to theoretical ideas. In the early stages of this research I found that my understanding of the research problem was certainly influenced by the ideas that I was being exposed to through the historical material that had been assembled for the literature review in Chapter 1. At the same time I was also attempting to make sense of what I was reading by comparing and contrasting the views of different authors with my own experiences.

Biographical Information and Attributes of the Researcher That Have Influenced the Development of this Study

I admit that it would be misleading to present my views as "value free", or to deny the impact of strongly held personal beliefs. To address accusations of bias I have documented some biographical details in this chapter so that the reader is aware of the source of my opinions. While admitting that my background and personal views are likely to influence the study I have endeavoured to remain impartial. I have not distorted the findings to represent nursing staff in a favourable or unfavourable way. I have attempted to show different aspects of the nursing role, and the various developments that have had an impact on it. My intention has been to show the range of influences and their consequences, not to label certain developments "good" or "bad". I have been involved in services for people with learning disabilities since 1982 working as a student nurse, a Registered Nurse, and a Nurse Tutor. The commencement of my nurse training coincided with the introduction of a new syllabus for the Registered Nurse for the Mentally Handicapped (English and Welsh National Boards for Nursing Midwifery and Health Visiting, 1982). The introduction of the new syllabus followed a turbulent period in the history of hospital based services. The enquiry into Ely Hospital (1969) had been followed by enquiries into Farleigh Hospital (1971), South Ockendon (1974) and Normansfield Hospital (1978). These enquiries brought the conditions that prevailed in hospitals to the attention of the public. At the same time they made many people sceptical about the quality of care provided in hospitals and the role of nurses that worked in them. The new syllabus placed a heavy emphasis on the theories associated with the delivery of planned nursing care, the nursing process, normalisation and behaviour modification. This material had been included to transform the role of registered nurses, and the public's perception of them, so that it reflected the deliberations of the Court Report (Committee on Child Health Services, 1976), the National Development Group, and the Jay Report (Jay Committee, 1979). The work of the National Development Group and the content of the reports emphasised a movement away from medical, custodial care towards integration with the community and care practices that demonstrated an awareness of social and educational considerations.

I acknowledge that exposure to these theories is not synonymous with their acceptance or rejection. During nurse training students were encouraged to identify alternatives to institutional practices and to regard the community as the most appropriate environment for the delivery of nursing care. Despite the rejection of hospital provision as the norm for people with learning disabilities the researcher spent three years working as a Staff Nurse in a hospital. During this period the researcher witnessed many examples of high quality nursing care delivered in the hospital as well as some practices that reinforced the value of the ideas and philosophies embodied in the 1982 syllabus. The three years that I spent working in the hospital were divided between two groups of clients. For the first eighteen months I worked with people with profound and multiple disabilities. After eighteen months I moved to another ward where I worked with women that had emotional and behavioural difficulties. Each group had distinct and different strengths as well as needs. From my perspective the skills and attributes that underpinned the work with each group were very different. At the time it felt as if the move from one ward to another involved changing jobs as well as wards.

On the first ward the daily activity of the nursing staff was focussed on meeting the physical needs of the residents. Physical care involved washing, dressing, feeding people, and helping them to drink. Most of the residents were incontinent and they required assistance getting to the toilet and regular changing. The work was physically demanding because it involved a lot of lifting to move people in and out of wheelchairs to chairs, beds, baths and changing tables. Many of the residents relied on the ward staff to assist them with most of their daily activities. Although the residents' psychological and social needs were not ignored they were seen as less important than the tasks associated with physical care e.g. washing and taking people to the toilet. Most of the clients spent all of their day on the ward. When they did leave the ward it usually involved an activity, event or therapy within the hospital. The environment was similar to the "closed society" that has been described by Goffman (1961). The residents that I worked with had no prospect of paid employment and limited opportunities to engage in any recreational or social activities that enabled them to meet people who were not residents in the same hospital, or members of the hospital staff.

After eighteen months of working with this group of clients I moved to another ward to work with a different group. The behaviour of the women on the ward was described as "challenging". All of the women were ambulant and (unlike the previous ward) many of them were able to talk and articulate their thoughts and feelings. Most of the women could meet their own basic needs. They could eat and drink without any help, and wash and dress with minimal assistance. Most of them did jobs on the ward such as laying tables, tidying up and making beds. Some of them earned a small income or privileges by carrying out domestic work, such as making beds on the other wards. Nursing care was focused on the psychological needs of the residents. The outcomes recorded on the care plans often reflected the behaviour that had led to them being placed on the ward. Some of the women had been placed there because they had self-inflicted injuries, or because they had been involved in violent episodes with other people. Others were there because it was thought that they needed constant supervision. They were seen as especially vulnerable to exploitation. Although the women on this ward could exercise more independence than the men and women from the previous one they remained part of the "closed society" within the hospital gates and seldom left the grounds.

As a result of these experiences I became interested in the way that the services created different groups of service users, and different groups of staff that worked with them. In the hospital the daily routine encouraged a level of uniformity – the meals were all cooked in the same kitchen, all the residents would eat the same food at the same time, the staff changed shifts at the same time each day – but residents on each ward led very different lives. Similarly the staff working on each of the wards had the same titles e.g. Nursing Assistant, Staff Nurse, but nursing care on each ward was constructed differently. Some staff would express a strong preference for working with residents from one ward and a dislike for working on other wards. The memory of this experience made me think of the historical antecedents and precedents for "high dependency" and "low dependency" wards and the sort of work that was associated with each environment. After a preliminary review of the literature I began to assemble

material that reflected these ideas under the headings "Streaming and Classification" and "The Role and Function of Services".

Although I have described some of the aspects of my previous work that have contributed to my assumptions about services for people with learning disabilities, nursing, and caring, I have also been influenced by the national debate surrounding the role of learning disability nurses and their relationship to other branches of nursing, professions and care workers. Mitchell (2000, p.78) has used the term "parallel stigma" to describe the development of the relationship between people with learning disabilities and learning disability nursing during the twentieth century. Mitchell maintains that learning disability nurses have been marginalised because of their work with "deviant" groups. They have also acquired a "stigma by association" (Mitchell 2000, p.80) because of the institutions in which they work. The differences between learning disability nursing and other branches of nursing have been attributed to their curing and caring functions. Whereas other branches have adopted an ideology based on the cure of sickness, or the restoration of physical and mental health, the care provided by learning disabilities nursing has not been characterised as curative. This same division has informed historical analysis of the functions ascribed to institutions that were orientated towards curing or providing long-term residential care or containment for their residents (Andrews 1996, Wright 2000). Mitchell's study has explored the sources of conflict with other branches of nursing and the General Nursing Council. He has stated that learning disability nursing has been kept at arm's length throughout most of its history (Mitchell 1996, 1998). Describing its relationship with the General Nursing Council he cited Miss Cowlin (1926), a member of the Mental Nursing Committee. She made a clear distinction between the curing and what she has described as "educational" aspects of care when comparing the roles of "mental" and mental deficiency nurses:

> It is helping to restore the damaged mind. You can't restore mental defectives. It is not like mental. It is an educational problem only. (Cited in Mitchell 2000, p.79)

Debate surrounding the role of nurses within the learning disabilities services was also reflected in the Jay Report (Jay Committee, 1979) that recommended replacing nurses with another professional group based on social care.

Uncertainty about the future of learning disability nursing was evident when I was working as a Nurse Tutor based at Stoke Park. Steven Rose[1] visited the site to facilitate a discussion about the future of learning disability nursing practice. The material from his visit, and similar visits to other service providers, was incorporated into the "Continuing the Commitment" project (Department of Health, 1995). Those who attended the meeting discussed the closure of hospitals, the implementation of community care, and the impact of the health and social divide as it was envisaged in the Cullen Report (Chief Nursing Officers of the United Kingdom, 1991). As well as exploring examples of good practice for inclusion in the project the participants also articulated their doubts and uncertainties about the changes that lay ahead of them. Within the meeting people expressed concerns about the lack of support for learning disability nursing from the Department of Health and colleagues working in other nursing disciplines. Participants expressed strong feelings that would have corroborated Mitchell's belief that learning disability was held at "arm's length" by some colleagues and professionals working in health and social services.

In the period leading up to the closure of the hospital many people were anxious about the future and their jobs. Some of the respondents may have been reluctant to express criticisms about a service in which the value of nursing was questioned. In an atmosphere where there was a lot of anxiety and uncertainty it was an advantage to be perceived as an insider. Rather than suppressing my identity the interviews presented an opportunity to exploit it in order to gather more information. I believe that some of the interviewees would have been reluctant to engage with the topics under discussion if they thought that the information they were supplying was being given to someone who had not shared similar

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[1] Steven Rose, Brian Kay, and John Turnbull prepared the report of the Learning Disability Nursing Project. The aim of the project was to describe in detail the "skills and knowledge of learning disability nurses and the contribution they make to the support of people with learning disability". See Department of Health *Continuing the Commitment The Report of the Learning Disability Nursing Project* (London, 1995), 3.

experiences, or been confronted with the same sort of criticism. As well as providing some mutual ground for exploring their experiences my experience also helped me to interpret the interview material. Although many of the interviewees made positive comments about their work, and the services that they worked in, it was possible to understand why other people felt disillusioned with nursing, defensive about the role of learning disability nursing in particular, or perceived their skills within the discipline as undervalued.

While Mitchell's research has placed particular emphasis on the role of qualified nurses the interviews from this research have incorporated the views expressed by unqualified members of staff employed as Care Assistants. In many instances their views were similar to the views of the qualified staff when they stated that their own work was not considered to be comparable with the work conducted by other care assistants in different sectors of the health service. Some of their feelings were exacerbated by reactions from members of the public who could not understand what a learning disability entailed, nor could they comprehend the role of "care" staff working with people that were neither "ill" nor physically impaired. Some of the staff also mentioned that their jobs had been linked with the negative images of colonies and hospitals from the past. These feelings suggested the influence of a "courtesy stigma" (Goffman, 1963) developed through the long association between learning disabilities and institutional care. Knowing that the interviewer had similar experiences to the ones that they were describing may have made some of the interviewees more comfortable and willing to talk about their experiences.

One of the attractions of writing about the staff was the chance to record the views and experiences of a group of people that were often ignored and occasionally vilified. Some people felt the newspaper and television coverage that the hospital had received in the past was negative and the more positive side of caring was obscured by descriptions of poor conditions and overcrowding. The interviews gave people time to describe some of the details of their work in a context that did not suggest an expose. Although exploiting my identity as a nurse can be seen as manipulating the interviewee when I started interviewing I became aware of

interviewees using the research as a way of addressing their employers, or individuals working for the Trust. This did not invalidate the points they wished to make but when I was selecting material that I wanted to reproduce for this study I had to look for any names or details that would compromise the anonymity of employees and residents. In Chapters 6 and 7 the names of interviewees from published and broadcast material have been retained, but the names of any individuals that have been identified in the interviews have been replaced with pseudonyms.

Although seeing the researcher as an insider encouraged some of the staff to be more forthright during interviews it may have had a detrimental effect on some of the residents that I encountered. Being identified with the staff on the wards, or in the homes, would have deterred some people from disclosing information to me if they believed that it would compromise the relationships they had established with staff. Bricher (2000, p.781)) has stated that health care professionals have been seen as "oppressors" by disabled people. The power that they have been able to exert over people with disabilities, as well as the non-disabled researcher's manipulation of the research process, have been characterised as factors that perpetuate oppression (Oliver, 1999). During my visits to the hospital and community homes I met many of the residents who lived there. I was introduced to them as a visitor. Because I made frequent, short visits, to conduct an interview with one member of staff, I did not have many opportunities to get to know all of the staff team, or the residents. This made it difficult to gain some people's confidence or trust. Although it was possible to use ice-breaking techniques to initiate some conversations with interviewees it was not a solution that would be successful with most of the residents that I met on my visits. Many of the people that I spoke to were not able to make a verbal response. Some of the people that could speak had difficulty understanding what I said to them. They would repeat certain phrases without relating them to any part of the preceding conversation.

The interview questions used in this study required the interviewees to talk about their current work, their previous experiences and their knowledge of services for people with learning disabilities. They were also asked to predict what was likely

to happen in the future. All of the questions required a response that would involve the respondent in sorting material into past, present and future categories as well as utilising a vocabulary that was capable of conveying their views and experiences accurately. To ask the residents living on the wards and in the homes similar questions (and interpreting their responses) would have necessitated moving beyond an interview framework that relied on spoken questions and verbal responses, consequently I decided not to interview them. Although the aim of the research was to explore the history of service provision and the "professional task" I still wanted to include some material that acknowledged the service user's perspective. Fortunately material from the televised documentaries on Stoke Park had included interviews with some of the residents. The interviews relied on verbal exchanges between the interviewers and the interviewee. All of them had been filmed with people that could talk fluently. Their communication skills, and the type of experiences that they described, indicated that their ability to express choices and make decisions had created opportunities for them that were not available to residents who could not articulate their wishes. While their views were not representative of some of the people with learning disabilities that I had met the material has been included in this study because it provided a service user's view of Stoke Park.

Interviews

Before I commenced any fieldwork I had to obtain permission to proceed from the Research Ethics Committee at the Hospital. Once I had permission I negotiated access to staff through the ward managers. Because Stoke Park was the case study for the historical material the research setting and the research "problem" had already been established. The setting and the problem were closely bound together. Although I was working as a Tutor in the Nurse Education Centre at Stoke Park I had not worked on the wards there. The hospital that I had worked in had been closed for two years when I commenced this research. At Stoke Park I only knew the staff that had contact with the Nurse Education Centre so my initial contact was a phone call to Ward Managers explaining that I wanted to visit their areas and interview some of the staff. I also offered to visit the ward and discuss my research with the manger if she or he wanted more information. If the

Manager raised no objections I requested a date and a time to visit and conduct the first interview. Although my presence on the site, and the proximity of research subjects provided me with a "convenience" sample (Parahoo 1997 p.230, Punch 1998 p.193) the way in which individual interviewees presented themselves owed more to a "snowballing" technique (Parahoo 1997, p.234). A lot of the people that came to talk to me had heard about the study from other interviewees and they wanted to participate. Access to interviewees from group homes had to be arranged in a different way. Once again I established telephone contact with the Home Manager but I stipulated that I would like to interview those members of staff that had worked at Stoke Park. The criteria for inclusion were a willingness to be interviewed, and work experience at Stoke Park Hospital. Once I had a list of people that satisfied both criteria I arranged times for individual interviews.

My nursing practice led me to believe that experience, exposure to different groups of clients and the respondents' perception of their role would all have a significant impact on their impression of the services. I also believed that their working environment would exert a powerful influence on their perceptions. Primacy and recency effects have both been identified as strong influences on the way people form impressions of events. The influence of these factors could have been ameliorated by gathering information in a quiet room in another building or by inviting participants to attend interviews on a different site. Such an approach would have had the advantage of putting some space between respondents and their immediate work but this had to be weighed against several disadvantages. Any travelling would have required an increased commitment from the respondents resulting in more demands on their time and money. Different, or unfamiliar surroundings may have made them feel awkward or uncomfortable and less willing to volunteer information. After considering the advantages and disadvantages I decided to conduct the interviews in the respondents' workplace. This was convenient from an administrative point of view but it also allowed the respondents to remain in surroundings that were familiar to them. To reduce the disruption that would be caused by taking staff away from the clients and their other duties I made sure that I interviewed one or two people per visit, made

frequent, short visits rather than infrequent, long ones and limited visits in each area to one per week. In this way I hoped that I would not be depleting staffing levels and standards of care while research was in progress.

To minimise the impression made by a single group (based on age, gender, or ability) I selected a purposive sample (Parahoo 1997, p.232) using a variety of wards and homes where the residents had different nursing needs. I wanted to avoid a situation in which a significant proportion of respondents were likely to be heavily influenced by their work with a particular group. This may have led to a situation where a high percentage of the respondents were drawing on their immediate experience without reflecting the wider range of abilities, strengths and needs within the various people who use the services. The areas that were included in the sample included wards and homes that provided residential services for less able clients, such as people with motor and sensory disabilities, as well as wards and homes that provided services for more able clients who needed minimal support or supervision from staff. The sample also included homes and wards where the clients were not grouped according to their abilities or nursing needs.

At the start of each interview I introduced myself and told each interviewee that I was looking at services for people with learning disability, using a historical approach to make links between the past and the present. I informed them that there would be a particular focus on Stoke Park. I also told interviewees that I was interested in the day to day work of carers so their recollections and experiences would provide useful information. I did not go into any more detail at that time. This was not because I wanted to conceal anything from them. It was because in the initial stages of gathering data I was not sure how the material would develop. Although some themes were emerging from the literature I did not know if similar material would emerge from the interviews.

I was able to inform each potential interviewee that participation in the interview was voluntary, and that they could terminate the interview at any time if they wanted to. I also explained the presence of the tape recorder. Each interviewee

was informed that it was there to make a record of our conversation so that I could transcribe it later. I told them that when the transcription had been completed the tape would be erased. I also guaranteed that all of the interviewees would remain anonymous.

I aimed to gather 20 interviews. I wanted the sample to represent staff working in the hospital, and staff that had moved from the hospital into the community. The views of the latter group were interesting because they had an opportunity to compare and contrast their experience of working in the community with their hospital experience. Access to staff in the community homes that fulfilled the criteria for inclusion in the study was more difficult to arrange than access in the hospital. This was because a lot of the younger unqualified staff working in homes had not worked in a hospital environment. Most of the qualified staff had worked in hospital while they were training but many of them had not worked at Stoke Park. The sample of 20 interviewees reflects these difficulties; 12 of the interviewees were working on wards at Stoke Park and 8 of the interviewees worked in community homes. Because I arranged each interview separately I was able to maintain a balance between interviews with qualified and unqualified members of staff. The sample of 20 interviewees contains 10 interviews with qualified staff and the same number of interviews with Care Assistants. Most of the interviews with qualified staff were with nurses at Staff Nurse level.

I had used a pilot study (conducted in another Trust) to experiment with questions and interviewing techniques. During the pilot study I used an interview schedule with open questions. The questions were posed to stimulate the respondents' memory and to encourage them to evaluate developments in the services. I wanted the questions to be simple and short so that respondents would not have any problems interpreting them. Questions were phrased in a conversational manner so that they were not confounding. My opening questions were "Can you remember when you started working in the hospital? – "What was the first day like?" to elicit more detail I would ask supplementary questions e.g. "What were the buildings like?" "How many people lived there?" "Were they all men or all women?" "How many people worked there?" To get an impression of their views

on contemporary services I asked, "What are the good bits of the today's services?" and "What could be done to improve the current service?" When respondents gave short or vague answers I would supplement the initial question with a probing question such as "Why do you think that?" or "That's interesting – Can you tell me more about that?" Although these questions yielded the sort of information that was useful and interesting I was not satisfied with the schedule. It made my responses appear rather static and stilted. Although the interviews required more structure than an ordinary conversation I wanted the respondents to be able to talk, opine, and remember without too many interruptions wherever that was possible. I also wanted to be able to provide a stimulus to the flow of ideas if it seemed to be flagging or difficult for the interviewee. As a result I decided to use reflexive interviewing techniques rather than a standardised approach. In their description of reflexive interviewing Hammersley and Atkinson (1995, p.152) have written:

> Ethnographers do not usually decide beforehand the exact questions they want to ask, and do not ask each interviewee exactly the same questions, though they will usually enter the interviews with a list of issues to be covered. Nor do they seek to establish a fixed sequence in which relevant topics are covered; they adopt a more flexible approach, allowing the discussion to flow in a way that seems natural. Nor need ethnographers restrict themselves to a single mode of questioning. On different occasions, or at different points in the same interview, the approach may directive or non-directive, depending on the function that the questioning is intended to serve; and this will usually be decided as the interview progresses.

A flexible approach was a better tool for extracting more information from interviewees. I learned from the pilot that having room to manoeuvre so that I could adapt to each new situation, and each interviewee, was an advantage. A flexible approach did not prevent me from using any of the prompts or questions that I had already experimented with but they would only need to be used when the situation demanded it. It also offered the prospect of changing between a directive and non-directive approach if that became necessary.

Analysis

When transcription of the taped interviews was complete I had 100 pages of text. I transcribed all of the interviews - an activity that absorbed a lot of time during the

second year of this study! Each interview lasted between 30 and 40 minutes. In spite of the amount of time that it consumed transcribing proved to be useful. I was able to familiarise myself with the content of each interview, and recurrent themes and issues began to establish themselves in my mind. Categorisation of data from documents and the interviews was developed using "middle-order categories" (Dey 1993, p. 104). A middle-order approach offered a compromise between the grounded theory approach described by Glaser and Strauss (1967), and categories established through "general comprehension of the data" (Dey 1993, p.104). In the former categories are established through a bit-by-bit analysis where the significance of each bit of data is established by comparing and contrasting it with other bits of data. The aim is to generate theory that is fully grounded in the data. In the latter there is greater emphasis on a holistic approach where "broad categories are distilled from a general overview of the data" (Dey 1993, p.104).

Dey (1993, p.104) has asserted that most data analysis "falls some way between" these approaches. Distinctions between the two approaches can be overdrawn:

> In categorising the data, the analyst has to work at each of these levels. A holistic approach has still to be rooted in the data, through middle-level categories and bit-by-bit analysis. A middle-level approach has to be geared from the start to the development of a more detailed and integrated analysis. With a bit-by-bit approach the analyst must become more selective and integrative in subsequent stages of the analysis.
> (Dey 1993, p.105)

Developing middle-order categories allowed me to draw on some broad preliminary distinctions within the data using "common sense" categories that reflected similarities and differences. I was able to assimilate these categories into the themes that had emerged from the literature review. I also considered items that I judged to be important using my own experience as a guide. Dey (1993, 104) has stated that this approach is suitable for policy-oriented research where a policy agenda provides a source of categories for analysis:

> A middle-order approach is also attractive if the data, although qualitative, is not entirely lacking in structure. Policy issues and programme conditions in evaluative research, for example, can provide

> a framework for generating a middle-order category set which can already be anticipated in the identification of "key issues" used in collecting data.

The review of literature on the development of services and my experience as a practitioner had made me aware of the significance of continuity and change, as well as the impact of streaming and classification, and the deployment of resources. I was able to combine these categories with other categories that reflected the significance of the concepts, definitions, and characteristics that had been used to identify people with learning disabilities, and the changing role and function of services for people with learning disabilities.

Transcriptions of the interviews provided a record of the questions that had been asked and the respondents' answers. Data had not been constructed around themes or titles. To integrate material from the interviews with the themes it was necessary to code the data. Transcription had produced a written record that mirrored the conversational style of the interview. Some of the interviewees had been loquacious, others were brief, some used plain speech, and others made frequent use of analogy, metaphor or simile. To develop a coherent analysis I worked through the text of the interviews isolating key words and phrases that indicated the repetition of an idea, or the recurrent association of ideas, and allocating each of them a different code. When the content of all of the interviews had been coded it was possible to look for recurrent issues that were congruent with the themes that had been established from the literature (and to identify any significant issues that suggested changing the definition of the existing themes, or adding more).

Selecting the material that would be reproduced in chapters 6 and 7 was the next stage in the analysis of the interview data. In their description of field relations Hammersley and Atkinson (1995, p.103) have described the problems that researchers face when they study an area they are familiar with:

> In studying such settings the ethnographer is faced with the difficult task of rapidly acquiring the ability to act competently, which is not always easy even within familiar settings, while simultaneously privately struggling to suspend for analytic purposes precisely those assumptions

that must be taken for granted in relations with participants.

This is an apposite description of how difficult it can be for ethnographers to suppress their own views so that they do not overpower or obscure the views of research subjects during interviews. The problem is not restricted to the data collection stages of a study. When material is being analysed researchers have to avoid the temptation to concentrate on those points of view that are closest to their own. This can also involve setting statements or material in the text of a thesis or report so that it does not appear to be less significant than the other material that surrounds it. When I was selecting material for inclusion in chapters 6 and 7 I was careful to select items that represented the range of opinions that had been expressed about a topic rather than focussing on those statements that were compatible with my own beliefs.

In addition to representing the breadth of interviewee's opinions I also wanted to capture their "voices" by using direct quotations. This involved searching for quotations that could be inserted verbatim into the text. As well as looking for quotes that were indicative of breadth I also had to look for quotes that would make sense to a reader when they were reproduced. They could not be too long because this would permit a single interviewee to dominate a page or a section. On the other hand they could not be too short because they had to convey the interviewees ideas in their own words without being dependent on the supporting text (where my own writing could be seen as adulterating the views of the speaker). My selection of material was guided by an ethnographic analysis of rhetoric, particularly the use of synecdoche. I used Hammersley and Atkinson's definition of synecdoche (1995, p.249). They have stated that:

> It is a form of representation in which the "part stands for the "whole".
> It is not therefore, just a source of allusion; it is an inevitable feature of descriptions. In principle it is not possible to provide a description of anything that will furnish a listing of every conceivable attribute and detail. In practice most descriptions do not even approximate to an exhaustive listing. Equally what we treat as "data" are necessarily synecdochal. We select particular features and instances, identify them as somehow characteristic or representative of places, persons, or events. We endow particular fragments of observed or reported life with significance, precisely in the way choose and present them as "examples", "illustrations", "cases" or "vignettes".

Hammersley and Atkinson have also stated (1995, p.248) that the principled use of synecdoche is more likely to be regulated by craft judgements rather than the application of formulae. In this study economy and redundancy were considerations that had an impact on the selection and inclusion of material. Economy meant that some statements from interviewees could not be included because there was not enough space for them. Redundancy involved the avoidance of repetition e.g. interviewees that had expressed the same, or similar ideas using different words.

Dey (1993) also provided some practical advice that I used to refine my selection of material from the interviews and documentary sources. Dey maintains that grammar can only serve as a rule-of-thumb guide to selecting bits of data. Because ideas may be expressed succinctly or expansively the number of words is not as significant as the meaning they convey. When selecting quotations from the data my underlying consideration was the relevant "unit of meaning" (Dey 1993, p.115) which is conveyed by content rather than form. Dey (1993, p.115) suggests that researchers should aim to select date that is "self-sufficient":

> Does the bit of data present an intelligible and coherent point which is in some sense self-sufficient, even if we cannot fully grasp its meaning out of context? We may look for natural breaks and transitions within the data – often but not invariably reflected in grammar - which distinguishes one "unit of meaning" from another.

When I chose quotations that would be included in the study I attempted to select passages which had captured an irreducible unit of meaning. I believed that this approach respected the integrity of the data and ensured that bits of data were meaningful both internally, and with respect to the overall analysis.

When I had completed the fieldwork, transcription, and analysis of the interviews, I began to plan the structure and sequence of material that would be used in Chapter 6. At the planning stage I realized that the first section on concepts, definitions, and characteristics would be very brief compared with the same section from other chapters. This was because the time period that it covered was shorter than the time period in other sections (the same time frame

had also been covered in Chapter 4). The focus on contemporary events meant that the analysis of changing concepts and definitions could not reflect the succession of changes that a longer time period allowed. I had to make a decision between changing the thematic structure of all the chapters and altering the construction of one section in a single chapter. I chose the latter option. However it was necessary to set the interview material in context so I wrote the section on "Stoke Park 1960 – 1990" to provide this context.

This chapter has examined the research methods that were used in this thesis. It has looked at how phenomenology and positivism have contributed to research methods in the social sciences. Material has been focused on the development of a qualitative approach that has combined critical reflection and principles derived from ethnography. Chapters 4 and 5 will continue to examine the history of learning disability services using material from a review of the literature that covers the period between the implementation of the Mental Deficiency Act (1913) and the end of the twentieth century. Chapters 6 and 7 are focussed on events at Stoke Park using interview material that explores the staffs' impressions of the services.

Chapter 4

National Developments 1908 - 2001

This chapter will continue to examine the history of learning disability services using resources derived from a literature review. Material will examine service developments in the period between the implementation of the Mental Deficiency Act (1913), and developments at the end of the twentieth century. Due to the length of the period that has been analysed, and the magnitude of the changes involved, Chapters 4 and 5 will each contain 2 sections rather than 4. Chapter 4 will examine the concepts, definitions, and characteristics that have been used to identify people with learning disabilities, as well as the impact of streaming and classification.

Concepts, Definitions, and Characteristics That Have Been Used to Identify People with Learning Disabilities

Industrialisation and urbanisation accelerated the pace of twentieth century life and made the daily activities of employment, communication and socialisation more complex. The introduction of compulsory education in 1880 had made the classroom, and the norms and values that pervaded the school, the principle source of secondary socialisation. Streaming, and the subsequent division of the school population, had isolated those children in the classroom who presented teachers with a mixture of pedagogic and disciplinary problems. The Royal Commission on the Care and Control of the Feeble Minded continued the movement towards comprehensive and specialised services that followed the implementation of the 1899 Education Act. The Commission considered the future of those children who had been designated ineducable within mainstream schools and the role and function of the different services that they would require as they progressed form childhood into adulthood. As well as services for children they also considered the position of those adults that were known to be mentally deficient but remained submerged within a larger population that was resident in asylums, workhouses, prisons or the community.

From 1905 the evidence submitted to the Commission by a variety of experts informed the debate about mental deficiency and provided groundwork for the 1913 Mental Deficiency Act. The 1913 Act produced further recommendations for a separate system of administration and institutional care. The recommendations that followed were built on terminology that had been established in the Idiots Act of 1866, which distinguished between the terms "idiots" and lunatics and allowed for the development of separate services. Thomson (1998, p.8) has stated that with the passage of the 1913 Mental Deficiency Act the term mental deficiency "moved from being a medical term to a medico-legal category". The expansion of specialised services incorporated a number of competing definitions of mental deficiency that Thomson has identified as medical, legal, educational and social. The aim of this section is to establish the concepts, or labels, that have been attached to these definitions and examine the impact that they have had on the development of policy and services.

Amongst the factors that contributed to the variety of definitions used to describe mental deficiency were contrasting beliefs about the differences between mental defectives and the rest of the population. Jackson (1996, p.164) has argued that in the early voluntary idiot asylums, special schools and special prisons there was a prevailing belief that the mental processes found in the mentally deficient, and the rest of the population, were part of the same continuum. The views expressed in Report of the Departmental Committee on Defective and Epileptic Children in 1898 have been cited in support of this argument:

> From the normal child down to the lowest idiot, there are all degrees of deficiency of mental power; and it is only a difference of degree which distinguishes the feeble-minded children, referred to in our enquiry, on the one side from the backward children who are found in every ordinary school, and, on the other side, from the children who are too deficient to receive proper benefit from any teaching which the School Authorities can give.
> Jackson (1996, p.164)

These views, which supported the education of children labelled as "feeble-minded" children in special schools, and their preparation for an independent adult life, can be contrasted with the views expressed by Tredgold in 1910

(p.718). It was his contention that the concept of a continuum was untenable. He divided the population into two distinct groups; the normal and the pathological:

> As is well known, normal individuals differ greatly in the degree of their mental capacity, and consequently it might at first sight appear that the feeble-minded were merely the least intellectually gifted - the inferior members - of normal mankind. This is not the case. They belong to a totally distinct and pathological group. They suffer from a deficiency of mind, a failure of mental development, which is of precisely the same kind as, and merely differs in degree from, the states of idiocy and imbecility.

Tredgold's construction of feeble-mindedness, idiocy and imbecility presented them as three manifestations of a single, immutable condition. His views about the immutability of their condition placed a permanent barrier between those people labelled as mentally deficient and the people that he identified as members of "normal mankind". The identification of a distinct pathological group, combined with extant theories that pointed to the deleterious effects of inbreeding amongst particular geographical and social groups, vivified concerns about the degeneration of the race that had been debated since the 1860s. Fears regarding their reproductive capacity led to the depiction of specific social groups as a direct threat to the security and prosperity of the rest of the population. Towards the end of the century optimistic beliefs about the ameliorative effects of education were obscured by more pessimistic views about the accumulative effects that groups of people labelled as criminals, insane, feeble-minded and unfit, were having on the quality of civilisation. Pick (1989, p.184) has noted that by this time the notion of civilisation was imbued with a strong sense of "imperial mission". The unchecked growth of groups that were labelled as deviant compromised "the viability of the ideology of a cohesive and unified ruling race".

To combat the threat of degeneration there were proposals to introduce measures that would be used, in addition to education, to modify any inherited tendencies. Because inheritance was perceived as the link between criminality, illness, pathology, and degeneration the concept of segregation and supervision gained ascendancy, as well as proposals to tackle the root of the problem by regulating reproduction. Regarding the care of the mentally deficient permanent

segregation and supervision reduced the likelihood of transmitting the condition to future generations. Segregation of the mentally deficient would also allow movement between institutions so that the number of places in workhouses, gaols and asylums that were inappropriately filled with mental defectives could be reduced. In addition the provision of permanent care meant that the propensity for criminal behaviours, that were seen as a corollary of mental deficiency, would be contained and subjected to a regular disciplinary regime. Advocates for a segregated service maintained that it saved money because it allowed for the removal of mentally defectives that were inappropriately placed within the existing services (Dendy, 1899). It also offered a protected environment for people that were deemed to be at risk, and a potential source of risk to the rest of society.

The Influence of Medicine

Many of the ideas about pathology and mental deficiency that had their origins in medical practice pervaded other services e.g. education. This meant that analysis and discussion surrounding a range of social issues was translated into medical or pathological terms. The theories, concepts, classifications and vocabulary that circumscribed much of the debate had been generated from the high level of medical involvement in state funded provision for children with impairments. Doctors were strategically positioned to influence decision making at a national level through legislation. At a local level they also exercised influence through their surveillance of the classroom environment. Their position became stronger when assessment and diagnosis were established as the first stages in delivering services. It was the development of a body of medical knowledge and research that delineated the specific characteristics of mental defective. Medical records, writing and research catalogued the physical, mental and moral differences that separated "defectives" from the rest of the population. The generation of this knowledge allowed medical practitioners to assume a pivotal role in shaping the attributes of a specialised service.

Medicine was able to consolidate its dominion over services by extending its influence across both institutional and community settings. Doctors conducted clinical and academic work in the context of segregated institutions. They also

carried out work for the Board of Education in schools. Although they worked with people with learning disabilities in both areas it was not the case that doctors working outside institutions were "more accepting of mentally handicapped people within society or more optimistic about their responsiveness to teaching" (Potts 1983, p.183). Their writing and research set the tenor for the development of services and held sway over the intellectual, social and political discourse that surrounded them. Dr C.P. Lapage's textbook "Feeble-Mindedness in Children of School Age" (1911) combined language that expressed humanitarian concerns with eugenic ideas. The book was written for school medical officers, teachers and social workers. Although he advocated for efficient and effective care of the "feeble-minded", these aims were expressed alongside his views on the management of their reproductive capacity. Lapage's views complemented those expressed by Dr A. F. Tredgold in his textbook "Mental Deficiency" published in 1908. Tredgold's stance on eugenics was more assertive. His views on care and control were accompanied by an authoritative scheme of definitions and classifications. He described mental deficiency as "amentia" and characterised it as a "mental disease". In addition to describing the prohibitive effects of the disease on cerebral development he has also stated that it would prevent individuals from maturing and adapting to their environment. He believed that the overall effect was to render them unfit for any sort of independent life in the community.

The Mental Deficiency Act 1913

The Mental Deficiency Act of 1913 divided the population that had been given the generic name of "mental defectives" into different groups. Mental defectives were classified under four headings - "idiots", "imbeciles", "feeble-minded persons", and "moral defectives". The 1913 Act introduced the category of "moral defective" that allowed individuals to be certified on moral grounds alone. Both the "feeble minded" and "moral defective" categories extended the Act so that it incorporated those individuals that may have escaped recognition because of their "physical and mental proximity to the normal population" (Jackson 1996, p.165). Fears that were focused on the reproductive capacity of the mentally defective population led to the development of expansive medico-legal categories that amalgamated mental, moral and social characteristics. Race (1995, p.15) has emphasised that the categories in the Mental Deficiency

Act were used to describe the results of "defect" instead of attempting to provide any scientific explanation of what a "defect" was. While Tredgold maintained that social competence was the most appropriate criteria for identifying mental deficiency the use of psychometric testing provided an alternative set of criteria that were regarded as more objective and scientific. Binet and Simon's tests to measure "Intelligence Quotient" had been published in 1908, and then revised in 1911[1]. In the United States the American Society for the Study of the Feeble-minded had used differences in IQ levels to classify people labelled as "Idiots", "Imbeciles" and "Morons" rather than a generalised description of a person's behaviour.

The Mental Health Act 1959

In spite of pressure from people such as Burt, who advocated for IQ testing as the sole means of determining mental deficiency, the terminology and classifications established through the 1913 Act remained intact until it was superseded by the Mental Health Act of 1959. Research that had been conducted during the 1950s (O'Connor and Tizard, 1954, Hilliard and Mundy, 1954) pointed to the weakness of the relationship between the label "feeble-minded" and an individual's performance in IQ tests. O'Connor and Tizard found that in a sample taken from twelve thousand residents in institutions the average IQ of people labelled as "feeble-minded" was over seventy. Race (1995, p.20) has stated that:

> The point, therefore, which other authorities defined as the maximum level for "deficiency" was merely the average of O'Connor and Tizard's sample.

The Mental Health Act of 1959 changed the classifications that had previously defined "defect". It introduced the term "mental disorder" that encompassed "mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind". The headings of "idiots" and "imbeciles" and "feeble-minded persons were replaced by the terms "subnormality" and "severe subnormality". The Act did not make any reference to the group formerly labelled as "moral defectives"; in fact it made an explicit statement that nobody could be dealt with under the Act "by reason only of

[1] For more detail on the progress of intellingence testing see Chapter 1, p.14 - 17.

promiscuity or other immoral conduct". This has been regarded as tacit recognition of the "dangers" generated by the previous Act (Race 1995, p.23).

Despite the changes in terminology introduced through the 1959 Act the definitions did not specify what was meant by "intelligence" or "mind". The Act referred to "a state of arrested or incomplete development of mind" which included subnormality of intelligence. Heaton-Ward (1975, p.1) wrote that the word "mind" referred to something other than intelligence:

> embracing as it does other facets of an individual such as personality, character and temperament, the definition makes it clear that a person is not to be considered to be mentally subnormal merely because he shows defects of these other facets unless he is, in addition, subnormal in intelligence, although it makes no attempt to define what is meant by the latter.

Heaton-Ward went on to state that the criterion for severe subnormality was "ultimately a social one - namely, the incapacity for independent existence or for protecting oneself against serious exploitation". He stated that the Act "wisely" avoided any attempt to distinguish between severe subnormality and subnormality in terms of IQ. The rationale that he has provided pointed to the benefits that could be derived from the treatment and training that was available in hospital:

> There is, in fact, a wide range of IQ in patients who satisfy the criterion of severe subnormality on their admission to hospital. As a result of treatment and training they may become capable of leading an independent life and guarding themselves against serious exploitation, and can properly be reclassified as subnormal. For these reasons, any attempt to limit the classification of severe subnormality to persons with an IQ below 50 is both undesirable and not necessarily legally accurate.
> (Heaton-Ward 1975, p.2)

In Heaton-Ward's description of the 1959 Act there is an acknowledgement of the links between the Mental Health Act and the previous legislation. The severely subnormal category incorporated all of those people that had previously been labelled as idiots and imbeciles as well as a large proportion of those who had been categorised as feeble minded. The definition of subnormality used in the Act omitted the statement about living an independent life or guarding "himself"(sic) against serious exploitation. Heaton-Ward stated

that this inferred that the concept of subnormality was not incompatible with leading an independent life. He proceeded to describe the category of subnormality as containing many people "on the borderline of normal intelligence" as well as "a large proportion of the social problem group". His description of the former group suggested that the category was subjective, and open to interpretation, to such an extent that it incorporated some "patients previously called "feeble-minded" as well as many border-line cases not previously classifiable as mentally defective at all, but as dull and backward" (Heaton-Ward 1975, p.2). The disabilities of the latter group were manifest in "general inefficiency and inadequacy", a description resonating with the concept of a social problem group made from "mental defectives of the primary amentia type" that had been referred to in the Wood Report (Report of the Interdepartmental Committee on Mental Deficiency, 1929). The definition of subnormality from the 1959 Act has replaced the social criterion relating to an individual living an independent life, or guarding "himself" (sic.) against serious exploitation, with a medical one. People labelled as subnormal were distinguished from those people labelled as severely subnormal because they required, or were deemed to be responsive, to "medical treatment or other care or training" (Mental Health Act, 1959). Hospital services and medical opinion were key components within the Act. Underlying the Act is an acceptance that residential services should be located in hospitals. Medical recommendations regulated the admissions procedure, and determined the appropriateness of the labels that were used to identify individuals in receipt of services.

The United Nations Declaration on the Rights of Mentally Retarded Persons 1971

In the UK the Mental Health Act 1959 defined the characteristics of people labelled as "subnormal" and "severely subnormal" in terms of the differences that made their behaviour, and their receptivity to treatment, different from the rest of the population. Parallel with this legislative framework, an alternative scheme developed that utilised many of the ideas generated from the work that had been critical of medically led, hospital-based services. This scheme sought to reduce the impact of the differences that separated people labelled as "subnormal" and "severely subnormal" from the rest of the population by making explicit statements about their entitlement to the lifestyle and generic services

that most people experienced. The United Nations Declaration on the Rights of Mentally Retarded Persons (1971) reiterated the principle of Article 1 of the United Nations Declaration of Human Rights (1948) which stated that all human beings "are born free and equal in dignity and rights" (cited in Beacock 1992, p.406). The 1971 Declaration stated that mentally retarded persons have "to the maximum degree of feasibility, the same rights as other human beings". The United Nations Declaration of the Rights of Disabled Persons, adopted in 1975, reinforced the same principles. It stated that "Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible". Specific rights included:

1. The same civil and political rights as other human beings.
2. Help to become as self-reliant as possible.
3. Proper medical care and treatment.
4. Education, training and rehabilitation and guidance.
5. A decent level of living, including the right, according to individual abilities to secure and retain employment.
6. A normal living environment, within a family where possible, including participation in all social, creative or recreational activities.
7. Protection from exploitation, discrimination, abuse or degrading treatment.

(Cited in Clarke, 1982, p.209)

In the UK these rights were reinforced in the work produced by the Jay Committee (1979). Their philosophy of care included the following rights:

1. Mentally handicapped people have a right to enjoy normal patterns of life within the community.
2. Mentally handicapped people have a right to be treated as individuals.
3. Mentally handicapped people will require additional help from the communities in which they live and from professional services if they are to develop their maximum potential as individuals.

(Cited in Clarke, 1982, p.334)

The principles embodied in these declarations had significant repercussions for the configuration of services. As well as advocating for equal civil and political rights, improving access to education, training, and leisure facilities they also

affirmed the right of people labelled as "mentally retarded" and "mentally handicapped" to live within a family, in the community. The King's Fund document "An Ordinary Life" (1980) examined possibilities for translating the Jay principles into practice. The project paper approached accommodation by suggesting initiatives using "ordinary housing" in preference to provision based on a more institutional model.

The Education Acts 1970, 1981 and 1993

The Education Act of 1970 recognised that children with learning difficulties were entitled to receive the benefits of an education. This Act replaced the 1944 Act that had labelled children with profound impairments as "ineducable". The 1959 Mental Health Act had addressed some aspects of the terminology. It stated that children in the "severely subnormal" category were not to be regarded as "ineducable", but made the proviso that they may be "unsuitable for education at school". The 1970 Education Act (Handicapped Children) stated that all children, irrespective of the level of their impairment, were entitled to receive an education. The Act also transferred the responsibility for providing education for children in hospitals from Mental Health Departments to Education Departments. By 1978 the Warnock Committee had published its report "Special Educational Needs" that promoted the adoption of the term "children with learning difficulties" to replace the categories of educationally sub-normal (severe) and educationally sub-normal (mild) established under the 1970 Act. The Education Act of 1981 brought together the principles of entitlement and the terminology from the Warnock Report. It reaffirmed that wherever possible children with special educational needs should be educated in mainstream schools, alongside other children without special educational needs. The principle has remained explicit in the 1993 Education Act which lays a "duty on those providing for a child's special educational needs in a mainstream school to ensure that the child engages in activities of the school together with children who do not have special needs" (cited in Hall 1998, p.85).

The Mental Health Act 1983

A new Mental Health Act was introduced in 1983 that changed the terminology that had been used in the 1959 Act. The term "subnormality" was replaced with "mental impairment". Heaton-Ward and Wiley (1984) described the definitions

used in the Act as "much narrower than their predecessors". To be subject to the 1983 Act it had to be shown that a person had behaved in an "abnormally aggressive or seriously irresponsible" manner. This meant that a person labelled as mentally handicapped would not be subject to compulsory admission to hospital for treatment, reception into guardianship, admission under a hospital order or transfer direction with the same effect as a hospital order, unless their condition was accompanied by abnormally aggressive or seriously irresponsible conduct. Heaton-Ward and Wiley also pointed out that under the new Act the main requirement for classification was the same as the classification for mentally disordered people of "normal intelligence" suffering from psychopathic disorder. Gostin (1983, p.3) wrote that:

> The removal of the majority of mentally handicapped people from the scope of the provisions relating to long term detention goes some way towards satisfying those who claimed that the Act was inappropriate for this group of people.

Changes made to the terminology and definitions used in the Mental Health Act were indicative of more pervasive changes in the relationship between the providers and users of services. Simpson (1999, p.154) has expressed the changes in social policy as a change in the discourse between "economic" and "social" factors:

> Prior to 1979 there was no sharp division in government policy between the economic and social (Wilding 1992, p.109). The language of policy was such that, for all political sides, the user of services could not be construed as a "consumer" in any coherent sense. The discourse of the economy simply did not apply. However, "community" performs a neat discursive connection in being the physical and conceptual link between individuals as consumers, taxpayers and as having "care needs". The community paid, the community used. By creating a policy around this new locus the discourse of the economy entered that of social policy (and arguably vice versa, though to a lesser extent).

Community Care and the Market Economy

The introduction of the White Papers "Working for Patients" (1988) and "Caring for People" (1989) established new boundaries between health and social care. While the Mental Health Act 1983 contained an acknowledgement that it was not appropriate for the majority of people with learning disabilities to receive

services in hospital the White Papers looked at demarcation between health services and services provided by local authorities. Local authorities, working in collaboration with medical, nursing and other interests were given the responsibility for assessing, designing and delivering care (Millar and Sheldon, 1989, p.1422). Social services departments were to discharge their responsibilities by producing individual packages of care. Individuals were to receive services through a process of "case management" that incorporated the following stages:

- Identification of people in need, including systems for referral;
- assessment of care needs;
- planning and securing the delivery of care;
- monitoring the quality of care provided;
- review of client needs.

(Millar and Sheldon 1989, p.1422)

Although a mixed economy had been introduced to give the purchasers of services more choice "Caring for People" stated that local authorities had to secure provision within existing resources. Within a market system the users of services were also designated the consumers of services. "Caring for People" (DOH 1989, p.4) stated that the way in which community care was conceived would give people a greater individual say in how they live their lives and the services they need to help them do so.

The language of the White Paper, and the economic model behind it, created tension between rhetoric and resources. The impetus towards change that had been expressed as "rights" during the 1970s and 80s had been translated into the "choices" that were made by purchasers and consumers under the conditions of a market economy. In their analysis of the implementation of the NHS and Community Care Act (DOH, 1990a) Lloyd and Gilchrist (1994) identified a clear contradiction between the emphasis on user-led provision and the imposition of strict resource limits. Similarly Nally and Steele (1992, p.42) identified differences between the collective strategies of disabled people to lead their own services and the market economy of care:

> Disabled people stress the need for more collective and communal ways to challenge this oppression. Collective strategies which segregate those who are oppressed such as the user movement's advocacy of establishing its own services, sit uneasily beside

> strategies which promote the interdependence of those who need care and those who care for them. Both these approaches challenge competitiveness and self reliance alike and both are fundamentally inconsistent with the current political dictum that services must develop within the market economy of care and must be targeted in "those in greatest need."

Although the movement from hospital to community based care during the 1990s entailed a change in the relationship between providers and recipients of services the distribution of power between providers, purchasers and consumers has been debated. The changes in nomenclature denoted a transition from the role of "patient" to "citizen", "consumer", or "advocate" but the changes did not lead to a commensurate increase in the resources that were available, or greater congruence between the identification of individual needs and the allocation of resources. While giving consumers more choice did not automatically equate with better value, giving them access to the complaints procedures and other forms of redress that were identified as part and parcel of the market model did not equate with a more prominent role in determining their own welfare. Lloyd and Gilchrist (1994, p.138) stated:

> The market model may enable individual users to act on their own behalf through complaints procedures, or to utilise citizen's advocacy schemes to make their voices heard in the statutory sector, but it provides minimal scope for effective input into the planning and design of services.

In 1996 the introduction of the Community Care (Direct Payments) Act gave disabled people under 65, and people with learning disabilities under 65, an opportunity to receive a direct payment so that they could arrange their own care instead of the services that had been arranged for them by the local authority. Both the British Council of Organisations for Disabled People and the Independent Living Movement supported this private members' Bill because they believed that it would allow more disabled people to employ their own workers and manage their own care. Means and Smith (1998, p.60) stated that the Bill received "cautious" government support. While it was consistent with their philosophy regarding self-help and the mixed economy it set a precedent that could open the floodgates to public expenditure if similar measures were extended to other groups e.g. older people.

Streaming and Classification

While legislation and policy have been used to identify and separate people labelled as having learning difficulties from the rest of the population the label did not represent a homogenous group. The group of people labelled as having learning disabilities was subdivided and stratified using a variety of different categories and concepts. The delivery of services, such as the administration of a specialised system of education, or the management of a colony, was expedited through a process of "streaming". Translating policy into practice first of all created, and frequently redefined, boundaries around groups that were the recipients of services. It also had the concomitant effect of creating conceptual boundaries around groups that had been omitted or excluded from services. The material in this section will examine how the delivery of services has divided the community of people labelled as having learning disabilities and then brought them together in different groups according to age, gender, class and ability.

The aim of the Royal Commission and the 1913 Mental Deficiency Act was to produce a more rational and efficient system for delivering care to those people receiving services. It also recognised the existence of a larger group of people, who were not receiving services, but were deemed to need "care and control". Before the Act a practical distinction had been made between those people who were able to cope with living on their own, or with support, and those who could not. People in the latter group were likely to be placed under care if they were deemed to be socially at risk, to constitute a risk themselves or to be socially incompetent (Thomson 1998, p.8). The services that developed continued to construe need in terms of protecting vulnerable people, protecting the community and providing assistance for individuals and families that were not coping on their own. At the same time the development of specialised services revealed that the social construction of mental deficiency focused those services on groups of people brought together because of their class, gender and culture as well as their "needs".

Moral Concerns

The passage of the Act occurred at a time when the reproductive capacity of mentally deficient women, and their potential for proliferating venereal disease,

was causing concern. Simmons (1978, p.394) has stated that women were identified as the biological source of mental deficiency. The ways in which their bodies were used, or abused, by men and the conduct of their sexual relationships were seen as a threat to sexual and familial morality:

> The social problem of mentally deficient women, therefore was complex and had serious ramifications. Not only were they seen as the biological source of mental deficiency, they also posed a deep threat to existing middle-class and respectable working class notions of sexuality and familial morality. This explains the near hysteria which characterises discussions about the social problem of mentally defective women. In the hearings of the Royal Commission, in the literature of the time, and during the debates in Parliament over the Mental Deficiency Act, case after case is cited of feeble minded women bearing large amounts of illegitimate, feeble minded children, who in turn, bred more feeble minded children.

Thomson (1996, p.210) has noted a change in the discourse of sexuality in the early twentieth century that moved away from protecting vulnerable individuals towards protecting the community. In the late nineteenth century concerns had been focused on protecting vulnerable women from vice. By the early twentieth century the emphasis was on the danger that "morally unstable" women posed to home coming troops because they were a likely vector of infection. Thomson's study of fifty five case history files from the London County Council showed that there were clear differences in the types of provision available for boys and girls. Girls were more likely to removed from their homes so that they could be placed under stricter control, while boys were more likely to receive supervision (Thomson 1996, p.211). Similarly there were differences in the duration of institutional provision. His sample of thirteen female cases showed that they spent an average of 32.7 years in institutions. There were only four long term male cases. It was more likely that males would be released on trial after a short stay, or paroled on license for lengthy periods.

Simmons has cited a statement from Gershom Stewart, discussing his Feeble-Minded Persons Control Bill (1912), to demonstrate the links between ideas concerning sexual control and the provision of segregated homes and colonies:

> What we advocate is that these persons (mental defectives) should be segregated in homes and colonies, especially the women during the childbearing period They (mental defectives) are paupers in the making from the very cradle, and, when the females get to a certain

> age, they are, I am sorry to say, exploited to a very considerable extent by unscrupulous men to their great undoing and to the great increase of youthful depravity in both sexes. Half the girls in our rescue homes are feeble minded and of 15,000 births that take place annually in our workhouses a very great number come under the same category.
> (Cited in Simmons 1978, p.397)

The passing of the Act created an intellectual and administrative bias that persisted after the concerns that had been expressed over eugenics had died away. Thomson (1996) has asserted that the Act was introduced for social reasons and not to meet the needs service users. Once a statutory framework had been established the forms and regulations established an "inbuilt bias" towards examination of the social and hereditary history of cases, and in many instances a focus on sexual factors, that led to an institutional solution. Although power resided with the authorities that interpreted, instigated and monitored the Act, families also used it to control the behaviour of dependants. Thomson (1996, p.221) has pointed out that parental concern over the sexual control of adolescent daughters probably contributed to a higher notification of female defectives.

When Josiah Wedgwood spoke out against legislation for the feeble minded he condemned it as the work of "eugenic cranks". He was critical of the way that it was directed at women, particularly poor women:

> If you were going to take a degree of variation from the normal as a sufficient cause of putting men or women - because this Bill is principally applied to women - (Hon. Members: "No") well, every argument brought forward has dealt with those unfortunate women who go into our workhouses to have children and so on, and the main argument has been against women and against poor women only. I say it is wrong.
> (Cited in Simmons 1978, p.398)

Although issues of gender and poverty were conflated he had anticipated that the legislation would be focused on some groups rather than others. In reality welfare workers could separate poverty from gender to align it with other constructs such as "respectability" and class. In Thomson's study a high proportion of individuals labelled as "neglected" came from social classes IV and V. Although this suggests that relative poverty was a factor that could lead

towards intervention it was not established as a criterion in the minds of welfare workers unless it was accompanied by other factors.

Macnicol (1983, p.177) has written that concern about the growth of a social problem group during the 1920s was fuelled by a combination of social, economic and political factors:

> mass unemployment, seemed convincing proof of racial degeneration, and the entry of working-class politicians into Parliament (albeit committed gradualists) heightened eugenists' fears that in conditions of mass democracy "the inefficient will always outvote the efficient"; thus dangerously changing the relationship of capital to labour.

In a period when democracy was being extended across class divisions the use of a conceptual framework that reinforced differences in social class could have been interpreted as harmful to the progress of democratisation. Under these conditions it was important for welfare workers to have constructs that divided families living in poverty into "good" or "bad" homes, and the working class into segments that were "respectable" or otherwise. Similarly it became increasingly important for the staff involved in delivering and administering services to develop a professional ethos so that individual differences, or differences in class were subsumed by professional judgement. Thomson (1996, p.216) has stated that ideas about "respectability" were central to the working class domestic economy and not an ideological tool that the middle-class used to control working class behaviour. Respectability was a criterion that was used to separate families that were allocated to the "social problem" group from "good" families. The concept of a "good" family was not incompatible with poverty. If a person labelled as mentally defective had what was considered to be a "good" home, and did not meet any of the other criteria that indicated a need for more stringent control, the authorities were often reluctant to intervene.

In the 1908 Children's Act the definition of neglect incorporated failure to provide (or secure through provisions made available for the relief) material resources such as food, clothing, lodging and medical aid. If failure to provide material resources had been the operational criteria for identifying neglect then many more impoverished families, as well as families from social classes IV and V, would have been the object of interventions. Welfare workers developed

more sophisticated criteria that enabled them to extricate families that were designated as "problem families" from larger groups that had been built around schema utilising poverty and social class. The criteria that were constructed combined an assessment of the physical environment with an assessment of the familial emotional environment. These criteria reflected the incorporation of psychological theories into a body of craft knowledge that distinguished the professionals involved in childcare from lay carers. The development of professional practice around child care meant that an assessment could be interpreted, and legitimised, as a collection of "facts" compiled around scientific theories instead of a judgement that reflected differences in the attitudes, values and beliefs that separated the assessors from the people being assessed.

Boundaries that defined groups requiring services moved as the concepts (and resources) that guided policy, legislation and "practice" shifted. While concerns about morality and reproduction were prominent during the passage of the Act, and the years that followed its implementation, the situation regarding the boundaries between community and institutional care changed during the 1930s. Thomson's study of a sample of cases from the London Association of Mental Welfare (LAMW) describes a transition from moral concerns to a growing interest in environmental and economic circumstances:

> A record was made of the rent paid by the parents, the size of the house, and the employment and salary of parents. Defectives were described in terms of employment potential. Note was made of school records, including type of manual training given, the abilities of the defective, and the recommended future employment. Having left school, the visitors recorded the defective's history of subsequent employment, the level of pay, the duration, the reasons for termination of employment. The reports were guided by an attitude which saw self-support, rather than control of moral behaviour, as the central problem.
> (Thomson 1996, p.217)

Changes in the nature of the assessment process were accompanied by changes in the status of the assessor. Between the passage of the Act and the 1930s the LAMW evolved from a voluntary organisation to an organisation with statutory status.

High, Medium and Low Grades

In a community setting assessment criteria were focused on self-support, and the social and economic conditions that underpinned an individual's daily life. Utilising these criteria to develop services meant that "need" was interpreted as the extent to which an individual was dependent on another person, or people, to support them. In an institutional setting an alternative model had been developed that "graded" inmates according to their capacity to contribute towards communal goals. The apportioning of tasks between "high-grade" and "low-grade" patients points to the mini-economy within a colony. Goods and services were distributed in the interest of economy:

> In the institution taking only lower grades, the whole of the work has to be done by paid staff; in one taking only high grades the output of work is greater than is required by the institution itself and there is difficulty in disposing of it. In the all-grade institution, on the other hand, the high grade patients are the skilled workmen of the colony, those who do all the higher processes of manufacture, those on whom there is a considerable measure of responsibility; the medium-grade patients are the labourers, who do the more simple routine work in the training shops and about the institution; the best of the lower-grade patients fetch and carry or do the very simple work.
>
> (Interdepartmental Committee on Mental Deficiency1929, p.22)

The presence of high-grade inmates, capable of undertaking "skilled" work within the Colony, conflicts with the idea that people capable of supporting themselves were encouraged to remain in the community. Thomson (1996: p.218) has provided a list of reasons that indicate why families were compelled to make a "reluctant request" for institutional care. Reasons included retirement or death of a parent, and the arrival of new siblings. These reasons suggest that the economic aspects of self-support were not the only factors that had a bearing on institutional care but they should be placed alongside other evidence which suggests that the labour of "high-grade" patients was used to reduce expenditure on staff and goods. An economy that utilised the labour of the higher grades to carry out the "higher processes of manufacture" and assume "responsibility" for their conduct relied on the presence of people who had the potential to be "self-supporting" in the community.

The descriptions of the relationships between "high", "medium" and "low" grade patients involved a precarious balance of skills and dependency. If the

population of an institution contained too many "low-grade" patients it would not be economical because it relied on the "waged" labour of the staff. If the population of an institution contained too many "high-grade" patients then it would not be efficient because the output of work would undermine a fundamental belief in the social incompetence of the mentally deficient. Once these beliefs were called into question the division of power that separated the social problem group from the people who had assumed responsibility for managing them would have to be renegotiated. The Colony solution was more than a "rural idyll"; it was laced with a twisted Utopianism. Within a colony the meritocratic system that dominated the world outside was replaced by a system that elevated interdependence and mutual aid above individual endeavour. Managers of institutions were expected to use categorisation, in the form of grading, to achieve a balance in the proportions of productive and non-productive patients in a colony.

The National Development Team 1978

During the 1970s the National Development Team (NDT) produced a classification scheme utilising criteria that assessed skills and levels of dependency. The scheme was used to assess the hospital population. It amalgamated assessment criteria into four groups, and correlated each group with an "opinion" on the type of accommodation that was suitable for each one. Group I was the least dependent group:

> Group I
> Criteria:
> Competent in all areas of self-help, ambulant, continent, no behaviour problems, not disruptive in any way.
> Opinion:
> Could be discharged home or to a hostel immediately without any special facilities necessary for management, apart from those normally provided in a local authority hostel. Some may be appropriately placed in group homes.
> (NDT, 1978)

Unlike the plan that had been produced for the Wood Report (1929) the NDT scheme looked beyond the institution to different types of accommodation outside the hospital. The residents were not seen as "workmen" or "labourers" in a colony that had to use its own resources to sustain a separate community. Competence was linked to discharge and residence with a family, a local

authority home or group home. Implementation of the scheme entailed dividing and then dispersing the hospital population. The types of accommodation that were mentioned involved smaller residential units and the formation of smaller groups of residents composed from people with similar abilities.

The criteria for Group II show that the purpose of grading residents had changed to match the changing dynamic of the institution. While the colony required a form of assessment that measured an individual's ability to make a contribution to the labour that was required to maintain all the residents, the NDT scheme assessed competence as a prerequisite to placing an individual within a framework of residential services:

> Group II
> Criteria:
> Continent, ambulant, almost completely self-sufficient with mild problems of behaviour which could be corrected with a short period of treatment and self-help training. A number could be considered for self-care training units.
> Opinion:
> Should be suitable for discharge home or to a hostel after a period of pre-discharge training.

The notion of competence had been transformed in two ways. Firstly it had been detached from its former association with labour or skilled work. Secondly it had changed from being a measurement of the contribution that an individual made towards "common" goals to an assessment that was focused on self-help skills. Competence was construed as the amalgamation of a number of factors related to self-care that included continence, mobility and the management of behaviour problems. The changes were denotative of a policy to encourage mobility within the services that were available. Provision in the community was described as "home", hostel, local authority home, group home or generically as "care in the community".

Implementation of the scheme meant that a homogenous group of people that had been defined by their residence in a "colony" or "hospital" had to be regrouped and redefined. Mobility entailed separation from one another as well as being relocated in different types of accommodation. The number of options in the scheme that aligned individuals with services in the community signalled a diminishing hospital population. For Groups I and II the hospital had become

an intermediary stage in the transition from institution to community. Assessment and streaming were functions that were delegated to hospitals prior to discharge. The criteria and opinion for Group II accentuated a new function for the hospital that signalled the transitionary period between institutional and community care. Hospitals were to continue to provide training within prescribed limits. A period of training was seen as part of the process leading to discharge. Outcomes of treatment and training were related to the management of behaviour problems, or the development of self-help skills. Progress in either of these areas meant that the individual would require less supervision once they had been relocated.

The criteria for Group IV indicated that the people in this category had a variety of impairments or behaviours that were more difficult to modify through treatment and training:

> Group IV
> Criteria:
> Severe double incontinence multiple physical handicaps, severe epilepsy, extreme hyperkinetic behaviour, aggression to self and others
> Opinion:
> The majority require some form of residential care with a higher staff ratio than is required by those in Groups I, II and III.

People in this group required a form of residential care that provided more staff than people in Groups I and II. There was some recognition that the day to day management of incontinence, multiple impairment, epilepsy and challenging behaviours necessitated commitment from a group of staff that extended beyond the provision of training and treatment. A consequence of assessing individual competence and matching it with different resources was that it made the relationship between autonomy, dependence and social mobility explicit. While the criteria that had been applied to Groups I and II matched different levels of ability with a level of supervision, and type of accommodation that would be required to maintain an individual outside the hospital, the criteria for Group IV suggested more investment in specialised resources. The level of supervision, and the facilities that were required to support this group, meant that the cost of replicating the resources that would be required to deliver the same standard of care that was already available in hospitals was constraining.

Simpson (1999, p.154) has described a connection between competence and liberty that runs through the last two hundred years. In the field of learning disabilities an individual must demonstrate competence before being granted autonomy. This is an "inversion of the principle of social intervention that holds for the rest of us". The promotion of behavioural competence, its advancement through teaching and training, and its relationship to the concept of independence has been a focal point for the development of services. In spite of an ideology like normalisation, that has linked it with a wider demand for the recognition of the moral rights such as dignity and respect, the delivery of services has made competence a divisive issue. Individuals that have been able to demonstrate an increasing level of competence, or a capacity to respond to treatment and training, have been seen as the beneficiaries of community care. Those individuals that have not demonstrated a capacity for change, or an aptitude for developing self-help skills, have made legitimate claims to the same moral rights but the services they have received appear to be orchestrated around the principle of "incompetence management", or economy and efficiency, rather than individual rights.

Health and Social Care

The identification of a range of needs and levels of supervision led to the reconfiguration of different groups within services. In 1990 Cullen proposed to make a strategic division between services using a bipolar model that separated health care from social care. In a report produced for the Chief Nursing Officers of the United Kingdom (1991) he described options for the distribution of services between the providers of Health and Social Services. The proposals did not present an argument for segregated services. They were described as "inextricably linked" (Chief Nursing Officers of the United Kingdom 1991, p.10) and the boundaries allowed individuals to move between the poles of health and social care. In spite of these provisos descriptions of the characteristics that signalled orientation towards health or social care reinforced many of the previous criteria that had pointed an individual towards the community or institutional provision. People in the social care group did not require services that were specifically designated for people with a mental handicap. Their needs included homes of their own in ordinary housing and support to use

ordinary services (Chief Nursing Officers of the United Kingdom 1991, p.11). They had no health problems or behavioural difficulties that could not be dealt with by the services that were available to other citizens.

Individuals that required health care needed support from "highly trained staff" (Chief Nursing Officers of the United Kingdom 1991, p.12). This group contained people with seriously challenging behaviour (such as self-injury), profound and multiple handicaps, significant mental health problems and sensory disabilities. The Report stated that because they were the only large workforce with the appropriate skills nurses should be "closely involved" in the care and treatment of such clients. The criteria for defining membership of this group resemble the list of physical and behavioural characteristics that comprised membership of Group IV in the earlier scheme. It was harder to provide suitable accommodation, and a satisfactory level of support for people in this group, outside the hospital environment. Cullen's report made the historical association between the needs of this group and the provision of nursing care but it stated that they did not need to live in the "traditional long-stay hospitals" (Chief Nursing Officers of the United Kingdom 1991, p.12). Instead of reinforcing the established links between nurses and hospitals it asked for recognition that "mental handicap" nursing skills were facility independent, and advised that the health care needs of the group should be met in the community.

Specialised and Generic Services

Work commissioned by the Department of Health continued to explore the ramifications of developing services within a mixed economy. The document produced by Kay et al (DOH, 1995a) divided the commissioners of services into five groups covering child health, health surveillance and promotion, the independent sector, Local Authority Social Services Departments, and services for people with challenging behaviour. It was envisaged that the recipients of these services would have access to all of the services that were available to "the general population" (DOH, 1995a). In addition to generic services, providers would develop specialised services capable of responding to groups with health-related needs, and groups that were deemed to be at risk. The health problems associated with learning disability were:

- epilepsy
- communication problems
- obesity
- cardiovascular and gastro-intestinal abnormalities
- respiratory problems
- impaired mobility
- mental health problems
- Alzheimer's disease (in people with Down's syndrome)

(DOH 1995a, p.8)

The publication "Health of the Nation: a strategy for people with learning disability" (DOH, 1995b) also directed health services towards a reduction in the incidence of coronary heart disease and strokes, cancers, HIV/Aids and sexual health, accidents, and mental illness. "Continuing the Commitment" (DOH, 1995a) cited the findings of Moss and Turner (1995) to define groups that were at "particular risk". They included people who:

- have multiple or complex needs
- are in crisis or where crisis is thought to be imminent
- are undergoing some form of transition e.g. from hospital to community, from children's to adult services
- are from ethnic groups
- are providing support
- are exhibiting behavioural problems or who may have additional mental health needs

(DOH 1995a, p.36)

While the formation of groups in the past had been precipitated by policies that were used to increase or decrease the institutional population, the groups identified by the Department of Health reflected a different set of priorities. Recipients of services were dispersed across broader geographical areas and between a variety of agencies and authorities providing accommodation. The hospital population had been reduced from 45,400 in 1979 to 13,900 in 1994. Instead of identifying groups within a particular environment, or measuring competence, they have been constituted around a specific problem or transitionary period in an individual's life. Although a health related problem might have necessitated prolonged contact with health services the constitution of a number of different groups had enabled people to move in and out of various services at different stages in their lives.

The delivery of care envisioned in "Continuing the Commitment" (DOH, 1995a) could be construed as episodic; involving a combination of different providers at different times, rather than a monolithic service providing life long care. As well as services having to adapt to meet the requirements of purchasers in the community the constitution of the population they served continued to change. The demand for services that catered for the needs of elderly people had increased. This was the result of a combination of factors. Many children that would not previously have survived infancy were living into adulthood (DOH 1995a, p.36) and the life expectancy of adults had increased. The list of health problems indicated that the number of people requiring health related services was likely to expand as the population grew older. Children with complex problems such as multiple needs, respiratory problems, or cardiovascular and gastro-intestinal abnormalities would require services throughout their lives. At the same time individuals that acquired health problems during the latter stages of their adult life would stimulate the demand for more specialised services consistent with the needs of an elderly population.

Conclusion

Chapter 4 has examined the significance of terminology and nomenclature associated with the implementation of the Mental Deficiency Act 1913, the Mental Health Act (1959, 1983), the White Papers "Working for Patients" (1988) and "Caring for People (1989), and the NHS and Community Care Act (1990a). Changes have reflected the growth of specialised knowledge related to learning disabilities, and increasing involvement from a range of professionals involved in the health, welfare and education services. Changes in legislation and social policy have also reflected the changing dynamic between institutional and community care. Analysis has been focussed on the powerful influence exerted by medical practitioners culminating in certification under the categories of "idiot", "imbecile", "feeble-minded" and "moral defective" defined in the 1913 Act. Terminology and nomenclature have also reflected the importance of a mixed economy and the introduction of an internal market. Material in the chapter has referred to the impact of psychological and sociological studies in the 1950s and 1960s that identified the negative consequences of labeling and institutionalisation. The chapter also examined concepts and terminology that

have been used as an alternative, an accompaniment or a replacement for the medical and institutional models that were introduced at the start of the twentieth century. These include appeals to the "rights" of disabled people and the use of terminology that characterised economic relationships between the purchasers, providers of and consumers of learning disability services.

Analysis of the material cited in this chapter has shown that the identification of particular groups has stimulated the development of services. Services have also created, or reinforced divisions between different groups. Analysis of the services that emerged at the beginning of the twentieth century has shown that specific groups of people were identified as more vulnerable or threatening than others. In the late nineteenth century women with learning disabilities were perceived as particularly vulnerable to exploitation in the community. During the early decades of the twentieth century the discourse around sexuality changed so that women with learning disabilities were characterised as a threat to sexual and familial morality.

The template for a colony model that emerged from the Wood Report (1929) emphasized the need to develop large, "all-grade" institutions that accommodated men and women of different ages and abilities. The Report had responded to practices established in smaller private institutions whereby managers would reject "low-grade" applicants in favour of "high-grade" applicants. The cost of providing staff to supervise low-grade inmates and the labour supplied by "high-grade" inmates had made a significant impact on the financial stability of small institutions. The impetus to expand institutional provision meant that the balance of low, medium and high-grade inmates was an important factor in calculating the expenditure that was required to maintain each institution. Judgements about the level of supervision that an individual required were also a critical factor in the transition from hospital to community-based services in the 1970s and 80s. Analysis of assessment criteria has revealed a system of streaming that facilitated the transfer of more able residents to hostels and homes in the community, while less able residents were more likely to remain in hospitals. Analysis of policy pertaining to the development of services at the end of the twentieth century has shown that some groups are still perceived as vulnerable. These groups have been

defined by the difficulties they have experienced gaining access to generic and specilaised services in the community. They include people with multiple impairment, challenging behaviour, mental illness, and people from minority ethnic groups (DOH, 1995a).

Chapter 5

National Developments 1908 - 2001

This chapter will continue to examine the history of learning disability services using resources derived from a literature review. Material will examine service developments in the period between the implementation of the Mental Deficiency Act (1913), and developments at the end of the twentieth century. Due to the length of the period that has been analysed, and the magnitude of the changes involved, Chapter 5 will contain 2 sections rather than 4. This chapter will explore the role and function of services, as well as resources and responsibilities.

The Role and Function of Services

By the end of the first decade in the twentieth century the presence of physiological, mental, moral and behavioral characteristics were being used to divide people labelled as mentally deficient from the rest of the population. In the education system this led to the development of "special schools" for children that had not been able to make progress through regular classes. The label "ineducable" had also been applied to children whose mental and physical impairments were supposed to render them incapable of benefiting from education. Concerns that had been articulated by the Eugenics Education Society about the hereditarian cause of mental deficiency were linked with anxiety about an inter-generational underclass. Fears that the reproductive capacity of this group would exceed the reproductive capacity of the respectable working and middle classes had led to the cultivation of a belief in the incipience of racial degeneration. The Royal Commission had provided a forum for expressing these concerns and exchanging ideas about the management of the feeble-minded. It also combined the voices of lay members with voices from the rising medical, psychiatric and social work professions in a concerted lobby to develop services that were equipped to tackle the "problem" of mental deficiency.

Evidence gathered during the Commission indicated that the number of people that had been identified as mentally deficient, and the demands that they would place on services, were increasing rapidly. The professional groups that were emerging used this information to focus attention on the importance of their contribution to the development of specialised services. Although the lobby for resources, negotiations with nascent professional bodies, and the drive towards legislation that culminated in the Mental Deficiency Act of 1913, called on central government to take a more interventionist role the provision of services was facilitated through a mixed economy. Central government, the Home Office and the Board of Control had a pivotal role in coordinating policy and legislation but voluntary organizations, particularly those involved in community services that required licensing, supervision or guardianship, also had a significant role in service delivery.

One of the strategies proffered was to segregate the mentally deficient from the rest of the population and contain them "permanently in institutions built specifically for that purpose" (Jackson 1996, p.172). The cost of constructing purpose-built institutions explains why the expense involved in initiating, developing and maintaining services was shared between local authorities and voluntary, or charitable, organisations. In spite of the progress of legislation local authorities remained unwilling to build institutions, and the onset of the First World War meant that the Board of Control were not able to secure resources to initiate new buildings (Simmons 1978, p.399). However more accommodation was available by changing the role of some of the existing services. A reduction in the funding that was used to provide institutions for inebriates meant that it was expedient for some managers to transform their reformatories into institutions for the mentally deficient. Similarly sites like Stoke Park, which had been opened as an industrial school, and Sandlebridge, that had opened as a boarding school, were expanded. In addition to the schools they were enlarged to provide more residential accommodation and they also became multi-functional, providing a range of services in addition to education and training.

Concerns about eugenics and the transmission of disease fuelled the movement to use legislation, institutions and sexual segregation as a way of rectifying "moral" weakness. One of the functions of institutional care was to provide the supervision, discipline and restraint that were required to compensate for moral laxity. Although the formation of policy and services were oriented towards the control and containment of individuals the interests of race, nation, and state did not exclude the needs of families. Families were also responsible for instigating institutional care when it became too difficult to look after a child at home. The problems that they faced were similar to the circumstances that may lead to a request for support from the present health or social services. These included the unemployment, ageing, retirement or death of parents, and the maturation of the child. Thomson's study of case files from the London County Council demonstrate that admission was not always the result of coercive pressure from the local authority. He states that in some cases it was the parents who accused the authorities of failing to provide care (Thomson 1996, p.218).

The Growth of Colonies

Promoting the colony as the most appropriate model for residential care was a strategy to supply accommodation on a large scale without losing the potential to provide a range of therapeutic or educational activities. Gladstone (1996, p.142) has observed that the tendency towards larger-scale, longer-stay institutions with an adult population was apparent before the 1913 Mental Deficiency Act. As the older institutions filled with a static population the impetus towards activities was lost or unfeasible due to the pressures that large numbers of inmates put on staff and space. The development of colonies created the possibility of piecemeal expansion by adding to the existing building stock using wings, pavilions or villas. Creating a succession of smaller units helped to preserve the illusion of intimacy that was a prerequisite for "moral therapy" (Thomson 1998, p.114). The potential for augmenting sites with a school, or other accommodation for mentally defective children, was an incentive for providers to add to buildings that were already there and avoid the expense of starting from scratch.

Thomson (1998, p.120) has argued that the adoption of the colony model showed how medical opinion dominated policy decisions by rejecting any alternatives that threatened to undermine medical control. The decision to encourage investment in colonies curtailed interest in reviewing poor law relief or workhouses, the use of lay persons and the management of voluntary hostels. The plan for a colony contained in the Wood Report (Report of the Interdepartmental Committee on Mental Deficiency, 1929) proposed to use classification as a way of maintaining equilibrium between groups of inmates with different mental capacities. Grading inmates would prevent institutions becoming either warehouses filled with "low grade cases", or enclaves for the "high grades". Medical opinion made the judgement of the doctor that allocated defectives to particular grade axiomatic. It was envisaged that the doctors' ability to conduct this type of appraisal was crucial for the efficient management of a "modern institution".

Sterilisation

The case for expanding the services was bolstered by the information compiled for the report produced by the Wood Committee (1929). The Report noted a significant rise in the incidence of mental deficiency, from 4.6 per thousand in 1905 to 8.56 per thousand in 1927. Although the validity of the figures was contested because of the impact of registration, the Report drew attention to the widening gap between the number of defectives and the accommodation that was available for them. In 1927 there were 61,522 ascertained defectives in England and Wales and 5,301 beds in institutions. Set against the rising numbers heralded in the report the cost of institutional segregation was prohibitively high. Sterilisation was another option that the Committee had considered. It had been presented as a "humane" solution by some of its exponents because it allowed defectives to live alongside other people in the community and lead comparatively normal lives without fear of propagation. At the same time it appealed to the "fiscal retrenchment mentality of the middle classes to which eugenists tended to belong" (Macnicol 1987, p.303). Although the Brock Committee in 1934 recommended that voluntary sterilisation should be legalized the Board of Control were reluctant to put their weight behind it.

King (1999, p.64) has located the campaign for sterilisation within the "policy making elite". He uses the composition of the Brock Committee and relationship between eminent euginists in British society, Parliament and Whitehall to identify a small group of experts and advocates that were acting autonomously. Eugenic ideas had exerted a powerful influence on the British political elite in the decade before 1914. Simmons (1978, p.395) has cited the impact of Galton's work on inheritance and ability, concepts that combined mental and moral deterioration with the decline of the English race, and the work of the Royal Commission, as evidence of the intellectual and scientific foundations that were used to propound eugenic theories within the "educated class". King (1999, p.69) also cites Winston Churchill's decision to circulate Tredgold's address as evidence of Churchill's willingness to apply eugenic principles to the eradication of poverty. The selection of the Committee revealed that its membership was predisposed towards the introduction of eugenic sterilization. Members like Tredgold, Ronald A. Fisher (Vice-Chairman of the Eugenics Society), and Sir Laurence Brock were not impartial. Manipulation of evidence submitted to the Committee regarding the significance of hereditary and environmental factors contributing to the incidence of feeble-mindedness showed that the impact of the former had been exaggerated, and evaluation of the latter had been inadequate.

Attempts by the Eugenics Education Society to translate eugenic ideas into legislation failed to win popular and cross-party support. Although the Society had persuaded the Ministry of Health to set up a Departmental Committee any efforts to produce legislation were met with opposition from a variety of organisations. While groups like the Women's Co-operative Guild and the National Union of Societies for Equal Citizenship passed motions in support of eugenic measures they were countered by uncompromising resistance from the Roman Catholic Church and sections of the Labour movement. Medical and scientific opinions were divided. The mental capacity of some individuals made the process of obtaining voluntary consent for sterilisation problematic. In addition to problems relating to cognizance and consent some experts were dubious about the hereditarian basis of mental deficiency. Scientists like LS

Penrose pointed out that medical diagnosis of mental deficiency was only one aspect of a complex equation that had to incorporate additional social, political and legal factors (Macnicol 1987, p.303). Norton (1983, p.223) has presented an argument that shows eugenics as an issue that divided rather than united the interests of the professional middle class. While sections of the middle class may have been averse to the prospect of paying for institutional care other sections featured prominently in the delivery of services that were likely to expand with the progress of the welfare state. Searle (cited in Norton 1983, p.224) has pointed out that these groups were less sympathetic because they "sought to eliminate the need for welfare by breeding out all potential recipients of environmental treatments".

By the late 1930s the links between eugenics and mental deficiency had been weakened. The eugenic movement continued but it concentrated its efforts on positive eugenics. Scientific knowledge about inheritance, and a paradigmatic shift in the analysis of poverty, crime and unemployment made the connections between mental deficiency and social problems more tenuous. The study of inheritance revealed that the mechanisms of transmission were complicated and could not be predicted in the way that many of the eugenists had surmised. As scientific knowledge indicated the limits of what was already known the contention that a group labelled as "feeble-minded" could be isolated, and contained, seemed less viable. As these ideas became more common mental deficiency was no longer perceived as a national threat, or a racial disaster and some of the "impetus" behind the policy diminished (Macnicol 1987, p.310). The sense of urgency that had accompanied estimates of the fertility of feeble-minded women seemed exaggerated and the drive to create services that located and compulsorily detained people lessened. At the same time analysis of economic and social problems indicated that the existence of structural factors that would not be resolved by segregation. Macnicol (1983) describes "a growing Keynesian liberal-reformist consensus" that provided alternative explanations for the persistence of problems such as poverty, crime and unemployment. The solutions that were derived from this type of analysis pointed to the effective management of a mixed economy rather than the use of legislation and services to impose moral order on an institutional population.

In Germany eugenic ideas had been circulated in academic and medical circles throughout the 1920s. Binding and Hoche had published their influential contribution to the euthanasia debate in 1920 entitled "Permission for the Destruction of Life Unworthy of Life" (Burleigh 1994, p.15). In it they argued for the disposal of the "unfit". The Nazi party adopted these ideas and implemented them through their "euthanasie" policy. Germany's Eugenic Sterilisation Law was operative from the beginning of 1934, making sterilisation compulsory for everyone judged to have a hereditary disorder. When Hitler came to power the systematic elimination of the chronically sick and ill in asylums through starvation, overwork and gassing became the prototype for extermination camps at Dachau, Buchenwald and Auschwitz. In England public opinion had not been in favour of compulsory sterilisation. Some of the more cautious and liberal minded members of the Eugenics Education Society, such as Dr. CP Blacker (the Society's General Secretary), responded to shifts in public and scientific opinion and moved towards pro-natalism and "the safer waters of positive eugenics" (Macnicol 1987, p.309). Revelations of Nazi practice were particularly damaging to the Brock Committee because it had praised the German arrangements. In other parts of the world their practices had not received condemnation. Edward Larson (cited in King 1999, p.94) has quoted Alabama's health officer telling the state's legislature in 1935 "with bated breath, the entire civilized world is watching the bold experiment in mass sterilization recently launched in Germany".

Care and Control in the Community

Both Thomson (1998) and Walmsley et al (1999) have described community care as an adjunct to institutional care rather than its replacement. They assert that institutional and community care existed on a spectrum, developing alongside one another in an interactive process. Studies using the London Metropolitan Archives and local records in Somerset and Buckinghamshire have demonstrated that during the interwar period the range of provision was far more complex than a simple dichotomy between institutional and family care. In addition to provision for institutional care the 1913 Act had referred to guardianship and supervision. Licensing enabled institutions to grant leave of

absence to inmates if the homes that they went to met with the Board of Control's approval. Guardianship provided another route for "defectives" to leave the institution yet continue to be the recipients of "care and control". Guardians could be a relative, employer or adult that would act in loco parentis. They could receive regular financial assistance from their local authorities which put them in a stronger financial position than families without guardians, or families claiming poor relief, that only received ad hoc payments. Statutory and voluntary supervision afforded another category that allowed "defectives" to remain at home if they were visited by salaried officials, health visitors, school nurses, social workers or local mental welfare associations.

Figures produced by the Board of Control show that between 1926 and 1939 the numbers of people provided for under the Mental Deficiency Acts in institutions increased from 20, 297 to 46, 054. During the same period the number of people under statutory supervision also increased from 15, 733 to 43, 850 (this number does not include people under guardianship for which no separate figures are available). In their study of Somerset Walmsley et al. (1999, p.191) have identified the importance of developments outside the walls of the institution. They describe how the Central Association for Mental Welfare, with backing and assistance from the Board of Control, produced propaganda to get Local Mental Welfare Associations to start Occupation Centers. Combined with voluntary and statutory supervision, licensing and guardianship, Occupation Centers provided a network of surveillance in the community that was cheaper than institutional provision. The network was there to provide advice and support to "mental defectives", and their families, but it was also used to deter the former from marrying and producing children.

The Central Association for Mental Welfare had conducted a debate about marriage and the impact of sterilisation. In Somerset the 1927 report of the Sub-Committee had rejected compulsory sterilisation on the grounds that it would not reduce the expenditure that was required to maintain people in institutions. The Sub-Committee favored a voluntary sterilisation scheme that made it an option that could be chosen instead of lifelong segregation in an institution, or as a condition for discharge from such an institution. Sterilisation

did not obviate the demand for segregation. In 1926 the Central Association had argued against sterilisation and in favour of developing more institutional provision on the grounds that it enabled defectives to live with their "mental equals" and protected them from the "positive cruelty" of the outside world. Institutional care was also necessary to isolate those individuals who had committed, or reconnaissance suggested that they were likely to commit, acts that compromised the conditions of supervision or licensing. Part of the role of services providing surveillance was to extend the moral boundaries of the institution into the community. If an individual transgressed these boundaries their license was revoked and they were returned. Many of the concerns about sexuality and pregnancy that had been expressed throughout the 1920s were evident in the records of people on licence and guardianship orders through the 1930s and 1940s. Dorothy Atkinson's unpublished study has cited a number of incidents that led to people being returned to institutions including homosexual practices, "for associating with the opposite sex", "he was seen talking to a schoolgirl", pregnancy and "associating with undesirable men".

The National Health Service

At the end of the Second World War the diverse statutory bodies providing care were incorporated into a tripartite structure that established the foundation for the National Health Service. Hospitals were administered by Regional Hospital Boards and public health by local authorities. The Board of Control was replaced by the Ministry of Health, with the Ministry having responsibility for the supervision of hospitals (including mental institutions). Section 28 of the National Health Service Act stated that local authorities might "make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the aftercare of such persons". Section 51 stated that they were responsible for provision under the Lunacy and Mental Treatment Acts, 1890-1930, and the Mental Deficiency Acts 1913-1938. The responsibility for patients from Mental Deficiency Committees was transferred to Health Committees. Thomson (1998) has argued that the incorporation of small, specialised services into a larger system was not beneficial for the recipients of mental deficiency services. The introduction of a national system based on the principle of universalism gave the whole

population access to health and education services that had been restricted to poor people. Although this created the prospect of a rise in standards for the bulk of the population the distribution of resources within the Welfare State meant that interests of minority groups, with special needs, were relegated to the periphery of a system that purported to maintain a utilitarian ethos.

Another consequence of the integration of services in the National Health Service was dominance of the medical profession through their representation on the Regional Hospital Boards. Both the Mental Hospital Association and the Confederation of Health Service Employees expressed reservations about the dominance of medical representatives on the administrative councils and committees. The groups wanted more lay representation and the presence of nursing and ancillary professions on consultative committees. The impact of the psychiatric lobby on the Boards mirrored the outcome of negotiations with doctors over the provision of general health care. Mental health became a part of the psychiatric system, under medical control, instead of entering the mainstream of social welfare in the same way that general practitioners and hospital consultants had developed their services at the expense of health centers and public heath services.

Welshman (1999, p.208) states that Ministry of Health "adopted a cautious approach to the development of services". Some local authorities provided after care and social clubs, only a few employed psychiatric social workers or other specialized staff. At the same time financial restrictions prevented them from building more occupation centers and short stay hostels. In 1956 Tizard stated that overcrowding and the barrack like austerity of most mental deficiency hospitals had suppressed demand for new places so that a different approach to the delivery of services was required. He envisaged a system that was similar to the one found in mental health services using clinics, hostels and sheltered workshops rather than hospital-based accommodation. Tizard pointed out that most local authorities would not be able to sustain care in the community. A survey that he conducted in London found that even when services for mentally "subnormal" children were satisfactory occupation centers

were still based in "church halls", and only nineteen per cent of adults had attended them in 1955 (cited in Welshman 1999, p.221).

In addition to the research that Tizard had conducted while he was a part of the Social Psychiatry Research Unit studies conducted by Clarke et al (1958), and Clarke and Clarke (1959) made strong links between environmental factors, IQ and other measurements of ability. They also found positive associations between stimulating environments and performance. Work produced by the psychologist Gunzburg (1957) conceived a different role for hospitals in which they would become "rehabilitation centers" that equipped people with the skills required to live a more independent life in the community. Race (1995, p.54) refers to the gap that developed in the 1950s between research workers that were critical of the facilities for care and "those directly involved with caring for people with learning disabilities" or "those with power over admission and discharge from hospital". He believes that the work of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency was focused on the poor conditions in hospitals, and the impact of wrongful detention, rather than focusing on the lack of opportunities for rehabilitation. Following the Commission the Mental Health Act 1959 abolished (except in certain defined circumstances) compulsory detention and certification. Although the Commission had alluded to community care the legislation had not altered the status quo. Accommodation provided in large hospitals was the only alternative to keeping people at home.

The Hospital Plan 1962

In 1962 The Hospital Plan heralded a significant reduction in the number of hospital beds available for the mentally ill and "subnormal". In a speech that he made to the Annual Conference of the National Association for Mental Health (NAMH) during 1961 Enoch Powell, Minister of Health, had announced the "redundancy of no fewer than 75,000 beds". The rationale for this reduction was built on a prediction that the number of mentally ill people would decline due to improvements in treatment and rehabilitation. The plan showed that over the following ten years the number of beds would be reduced so that by 1975 there would be 1.8 beds for the mentally ill and 1.3 beds for the mentally

"subnormal" per 1,000 population (figures cited in Welshman 1999, p.211). A Ministry circular HM (61) 25 (cited in Jones 1975, p.322) specified that in the future hospital beds would be divided between acute beds in general wards, medium and long stay units, and units with secure accommodation. It was anticipated that some of the long stay units would be hostels or annexes of general hospitals. Improvements in the care of the mentally ill had been achieved through the extension of out patient treatment, more active in-patient treatment, and the rehabilitation of long-term patients. To maintain these improvements, and to prepare for the development of services for prevention and care in the community, the Ministry argued that local authorities needed to provide more residential hostels and training centers, and to employ more social workers.

The proposals that were made in the hospital plan were similar to the suggestions that had been put forward by Tizard and Gunzburg in the late 1950s. Tizard's studies had revealed that most local authorities did not have the resources at their disposal to expand community care services. The Ministry asked local authorities to prepare plans for health and welfare services over the next ten years. They were published in the "Health and Welfare" White Paper of April 1963. Welshman (1999, p.212) has stated that the White Paper had little value as an aid for planning but it did provide the Ministry with useful information about the current level of services. Information that was gathered from the Hospital Survey in 1962 showed that there were differences between mental health and "subnormality" services. Although it had been predicted that the number of beds for people with mental illness would decline the number of beds in hospitals for the mentally subnormal would have to rise due to an increase in the life span of the residents (Thomson 1998, p.295).

In the 1960s research drawing on the social sciences became increasingly critical of the care system. Goffman's "Asylums" was published in 1962. His criticisms of institutions pointed to the isolation of inmates and the lack of opportunities to establish social contact with people on the outside. Pauline Morris used research methods that were similar to those developed by Goffman to analyse the work of hospitals for the "mentally handicapped". Her study "Put

Away" was published in 1969. An earlier book, "Sans Everything - a case to answer" (1967) contained allegations against individual members of staff nursing geriatric and psychogeriatric patients. The disturbing nature of the accusations, and a number of similar incidents that were brought to the attention of Hospital Management Committees and Regional Hospital Boards, led to the establishment of a special tribunal appointed by the Secretary of State.

Hospital Inquiries

Hospitals for the "mentally handicapped" attracted the attention of the national media when allegations of cruelty and misconduct were made against staff at Ely Hospital, Cardiff and Farleigh Hospital, Somerset. The inquiry into Ely Hospital was initiated by the Minister of Health[1] in 1967 after he had received allegations from a correspondent working for the News of the World. Following the inquiry some of the allegations involving male patients, and some of the male staff were upheld. The report described conditions inside the hospital that raised concerns about the state of "subnormality" hospitals in the National Health Service. Jones (1975, p.6) has described the buildings at Ely as "too solid to knock down and too expensive to replace". This description is in accord with Goodwin's (1989) views on the conditions that prevailed in many of the old asylums providing residential accommodation for patients using the mental health services. Although they were filled to capacity in many cases they lacked the resources that were required to implement an extensive refurbishment programme. At Ely the local authorities had made no provision for community care and the voluntary sector was not supplementing the existing services. Poor buildings, lack of money and untrained staff had contributed to low standards of care. The report on the Farleigh Inquiry (1971) established a similar picture. Commenting on the report the NAMH stated that the situation at Farleigh could be replicated in hospitals all over the country:

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[1] Richard Crossman took a special interest in the evidence from the Ely Inquiry. He attempted to give impetus to efforts to reduce the extent of institutionalisation of care for the mentally handicapped and mentally ill. By doing so helped to put neglected issues on the political agenda. See M. Hill *The Welfare State in Britain A Political History Since 1945* (Aldershot, 1999), 82. See also Chapter 6, p.166 for Crossman's and Kenneth Robinson's visit to Stoke Park in 1969.

> We stress that these events might be repeated in many of the other hospitals for the mentally handicapped where the same conditions of shortage are to be found - that is, in almost all the 200 hospitals for mentally handicapped in this country.
> (Cited in Jones 1975, p.12)

The report on the inquiry into South Ockenden (1974) gathered evidence that confirmed the existence of bad conditions and the poor treatment of patients in another hospital in a different region.

Following the events at Ely a Working Party was set up to make proposals for improving the services. Members of the Working Party included Professor Peter Townsend and Dr Pauline Morris. In addition the Hospital Advisory Service was established and a White Paper drafted. The Hospital Advisory Service began to tour the hospitals noting any causes for concern and compiling reports that were given to the Regional Hospital Boards and Hospital Management Committees. A Health Service Commissioner was also appointed to reinforce the rights of people using the Health Service. Mittler (1979, p.4) saw these measures as a way of making services for the mentally handicapped more accountable. Although the inquiries, the reports and the coverage that they had received in the media, focused attention on hospitals the problems associated with the "historic isolation" of the services had not been resolved. Many of the professionals involved in delivering services exercised a degree of autonomy which allowed them to distance themselves from the people that received services and the communities that surrounded them. Mittler believed that there should be stronger lines of accountability linking services with clients, families, the local community supporting services, and the general public through representation in Parliament. The appointment of the Hospital Advisory Service and the Health Service Commissioner were initiatives that were intended to improve accountability. In 1975 the Development Team for the Mentally Handicapped was set up to advise health and social services authorities on the development of better services. The Hospital Advisory Service had been able to identify problems in specific hospitals but it had also drawn attention to the differences between hospitals in each region. The Development Team was able to offer advice on joint planning to promote a more consistent and integrated services across the country.

Hospitals to Community Based Care

The 1971 White Paper "Better Services for the Mentally Handicapped" defined clear principles of service delivery. The Paper proposed to shift the balance from hospital to community care. In relation to service users, families and carers it stated that each "handicapped" (sic) person should stay with "his" (sic) own family unless it resulted in an undue burden being placed on them or "him" (sic). Support for families would be provided through general social services, with additional specialized help available for people with severe multiple disabilities or "behaviour problems". When a person had to leave home alternative accommodation should be as homelike as possible, even when it was a part of a hospital. The Paper also made explicit statements pertaining to the co-ordination of services across administrative frontiers. Local authority personal social services for the "mentally handicapped" were to be integrated in the services that had been brought together under the Local Authority Services Act (1970). In addition it stated that there should be collaboration between these services and other local authority departments e.g. child health services and education, as well as stronger links with general practitioners, hospitals and other services for the disabled.

During the early part of the 1970s measures were taken to instigate 'the resettlement of people from hospitals into the community. The plans for hospital closure, and decanting the hospital population into smaller residential units, covered a twenty-year period between 1971 and 1991. Although the projected numbers showed a decrease in the hospital population from 52,000 in 1969, to 27,000 in 1991 (DHSS/Welsh Office, 1971) and a commensurate increase in the number of places available in local authority, voluntary, and private homes, in reality the transition from hospital to community was spasmodic. The rate of change accelerated during the 1990s. Between 1975 and 1995 there was a significant increase in the number of places available in community homes but the real growth was in the private sector, combining public funds with private supply (Le Grand and Vizard 1998, p.96), rather than the statutory or voluntary sectors (cited in Malin et al 1999, p.12). Although the number of hospital beds declined between the 1970s and the 1990s they

were not replaced by places in ordinary houses. A report produced by Emerson et al (1996) stated that around 26 000 places (approximately 63%) were in facilities offering 20 places or more. A policy impact study concluded that "little progress had been made overall since the 1990s to transform services in pursuit of significantly improved quality of life" (DOH 1999a, p.5). Facilities for long term accommodation and care were reliant on congregated residential provision. The study stated that two thirds of people in NHS settings, along with residential and nursing homes, hostels and village communities lived in a "non-domestic" setting (DOH 1999a, p.12). The disjunction between rhetoric and reality in relation to the provision of better quality accommodation and services in the community has been characterized by periods where the promulgation of policy has exceeded the capacity for real changes in the services. Edelman (1971, 1977) and Ham (1982) have described this process as "symbolic" policy making. Ham (1982, p.89) has used this term to refer to:

> action intended to demonstrate that something is being done about a problem, rather than action which is a real attempt to tackle the problem.

Symbolic policy making meant that the need for more fundamental reforms or strategic review was forestalled by producing policy statements that were intended to satisfy key pressure groups and stakeholders.

The lengthy process of decanting hospital residents into the community changed the constitution of the hospital population and the role of hospital based services. Jones (1975, p.96) commented on the ways in which staff characterised residents from "high grade" and "low grade" wards. She stated that the nature of "hospital nursing" would change once the residents from the high-grade wards had been discharged:

> ...for as the "good" high grade patients are discharged into to community care, so the hospitals will increasingly have to focus on the care of those perceived as "low grade". Their numbers will increase, because the population is rising and the mentally handicapped are living longer.

> Whether nursing staff like it or not (and the majority for obvious reasons, do not), the future of hospital nursing for the mentally handicapped is more closely related to the management of the kinds of patient to be found on the "back wards" than to the more stimulating, and more rewarding, work of the "good wards". The former hold the patients they are likely to keep; the latter hold the patients they are likely to transfer to community care.

Streaming and labeling the residents played an important part in making decisions about groups or individuals that would remain in the hospital and those who could be discharged without delay or with a minimal level of preparation. The scheme produced by the NDT (1978) showed that the dispersal of the hospital population would be expedited by correlating the skills and abilities of the residents with different types of accommodation. Residents that were continent, ambulant, presented no behavioural problems and possessed self-help skills were deemed to be suitable for immediate discharge.

Jones (1975, p.163) found that the people with places in training centers, and the people selected to live in hostel accommodation, were chosen from the more able groups. From a sample of 1, 877 trainees only 19 were liable to incontinence, 8 were deaf, 7 were blind or partially sighted, and 33 had problems of physical mobility. People that were incontinent, deaf or blind represented less than 2 per cent of all trainees. The profile of the trainee population "contrasted sharply with the hospital population, many of whom were severely and multiply disabled". In the hostel population incontinence was rare even though it was a problem that affected about a third of hospital patients (Jones 1975, p.169). Similarly hostel residents were largely able to feed, wash, and dress themselves whereas many hospital residents were unable to perform the same tasks without assistance from the staff. Jones (1975, p.171) also found that hearing and speech were significantly better in the hostel patients, although a large proportion of them had poor sight. In 1999 a Department of Health study reiterated that people with the most severe or complex needs have "probably been the worst affected" (DOH 1999a, p.5) by the reshaping of service provision. The study identified two specific problems in relation to the development of services for this group. The first

was a lack of clarity in relation to the present and future role of the National Health Service in providing long term care (DOH 1999a, p.4). The second problem involved confusion over funding and the absence of effective collaboration between the NHS and local authorities. The perseverance of problems relating to provision for this group has shown that they were the last to benefit from community care. Although discussion documents continued to affirm the importance of joint working (e.g. DOH, 1998) services for people with complex needs appear to fall into the divide that separated health and social care. The Department of Health (1999a, p.33) incorporated an agenda for consideration at national and local levels that exhorted both local authorities and health authorities to clarify and reinforce their existing responsibilities for the commissioning, management and regulation of services.

In the mid 1980s the number or private residential and nursing homes started to escalate. Expansion had been stimulated by the amendments to the supplementary benefit regulations that made it easier for low-income residents to claim their fees from the social security system (Evandrou and Falkingham 1998, p.197). Social Security funds that had been allocated for residential care were transferred to local authorities. As a result the overall number of places rose from 46,900 in 1982 to 161,200 in 1991 (figures cited in Means and Smith 1998, p.50). The Audit Commission report Making a Reality of Community Care (1986) described the changes in funding as a "perverse incentive" that stimulated the growth of institutional care at a time when Social Services Departments were attempting to extend community care by expanding domiciliary services (Means and Smith 1998, p.50). Although most of the new accommodation was for elderly people Hoyes and Harrison (1987) found that some health authorities were using the private sector as a source of alternative accommodation for moving people out of "mental handicap" hospitals.

The House of Commons Select Committee report on community care focused on adults with mental health problems and learning difficulties (Social Services Committee, 1985). This report was critical of the trend towards private institutional care. The conclusions from the report indicated that policy had

been biased towards resettling people from hospitals. In addition the pace of running down hospitals was outrunning the provision of alternative community based provision. Joint financial initiatives, and the criteria for the selection of pilot projects, had been responsible for the bias towards getting people out of hospital but the report also suggested that joint finance was no longer an effective way of transferring responsibilities from health to local authorities. "Mental disability" services were perceived as underfinanced and understaffed. Regarding future developments the report indicated that arrangements for joint planning needed to be strengthened, and that consumers should be included in the planning process.

The NHS Executive document "Signposts for Success" (1998) reinforced some of the conclusions that had been made in the House of Commons Select Committee Report (Social Services Committee, 1985). The document indicated good practice in commissioning and providing health services for people with learning disabilities. It urged commissioners and providers to work effectively across organisational boundaries and emphasized "a strong long-term commitment to joint working" (NHS Executive 1998, p.7). At the same time it clearly acknowledged that under the National Health Service and Community Care Act (DOH, 1990a) local authorities were the lead agency for assessing and commissioning services. Within this context health commissioners still had a role to play in providing alternatives to ordinary services when they were required, specialist mental health provision, some residential provision, and maintaining transitional responsibility for people still in "mental handicap" hospitals. Although the document did not advocate for joint funding it encouraged service commissioners to be fully aware of the mechanisms for funding both local authority and NHS services, and the formulas that were used in deciding the allocations. Joint planning was seen as an area where partnership and co-operation were particularly important:

> It is important to be familiar with the full range of local service provision and its strengths and weaknesses, in order to see the full picture. Partnership and co-operation should lead to a jointly agreed local strategy for learning disability services that includes the NHS role. There should be some officers designated to take the lead in this process.

(NHS Executive 1998, p.8)

Local authorities were also required to produce Community Care Plans each year. In addition the document also stipulated that health service providers should consult with people with learning disabilities, relatives and carers to know what they want and need when using health services (NHS Executive 1998, p.33).

A Department of Health study (1999a) identified that residential services had continued to develop across the statutory, private, voluntary and independent sectors. In spite of the range of accommodation available from a variety of providers it found that that the NHS contribution to long-term accommodation was still significant (DOH 1999a, p.12), accounting for 10 percent of all residents (long stay hospital 3.31 percent, NHS hospital units for continuing health care 5.36 percent, and NHS secure accommodation 1.31 percent). Regarding health services it found that for the users of NHS Trusts access to community services and specialist provision was good. This was not the case for people in Social Services accommodation where access to specialist Trusts, or primary care, was described as "variable" (DOH 1999a, p.18). Regarding partnership and the organization of commissioning it stated that in all of the sample authorities senior managers had met to review the coordination of services during the last year. However only 14 from a total of 21 authorities reported some evidence of formal joint commissioning arrangements, and only 13 out of the 21 reported that they had produced a joint strategy for 1998-2001. The report stated that the fragmentation of commissioning responsibilities in a number of authorities (within and between agencies) was a "significant problem" (DOH 1999a, p.25).

Resources and Responsibilities

The aim of the final part of this chapter is to look at the impact of the changing level of resources in services for people with learning disabilities. Material will examine the relationship between these services and developments in the welfare state. The relationship between funding administered through central

government, and funding through local authorities, will also be examined. Examination of the movement of resources between hospitals and the community, that has been a feature of the discussion in previous chapters, will continue in this section using issues around expenditure and investment to argue that the deployment of resources played a significant part in widening the gap that separated the rhetoric of community care from reality. During the discussion the responsibilities of different organizations working in the services will also receive consideration.

Developing a Mixed Economy

The passage of the 1913 Act was preceded by persistent pressure on agencies that were managed, or regulated by the state, to take a more prominent role in the delivery of services for people that had been identified as "mentally deficient". Material in Chapter 2 has referred to the alliance between Harold Burden, Sir WP Byrne and Dr. RW Branthwaite at the Home Office as well as Burden's endorsement of strict governmental control. Similarly Jackson (1996, p.168) has commented on Mary Dendy's endeavors to promote institutional care at a national level. He states that in her addresses, public articles, and evidence to the Royal Commission, she argued for state intervention in the matter. There was also persistent pressure from members of the Eugenics Education Society, and other people sharing their aims, for the government to pass mental deficiency legislation. Simmons (1978, p.395) has cited a campaign by The Times that supported the development of institutional provision. The cumulative pressure urging the government to take decisive action assisted the passage of the Act that devolved obligation for providing supervision, guardianship, or institutional care to local mental deficiency committees. Jackson (1996) has stated that the passage of this legislation ensured state support for institutions that had been provided almost exclusively from the voluntary sector.

Even though the introduction of the Act signalled more support from the state it did not entail a commitment to allocate resources at an unprecedented level. The correspondence between Harold Burden and the Home Office suggests that they envisaged voluntary and charitable organisations participating in a

mixed economy. Although the state was involved in developments at a national and local level its role was to regulate and maintain the conditions that would facilitate a mixed economy, not to assume financial responsibility for new services. Once the campaign to attract government support had achieved some success the "problem" of mental deficiency was juxtaposed against other matters of national importance. During the period that preceded the passage of the 1913 Act the hypothetical consequences of "degeneration" had been presented as a threat to national prestige. When the hereditarian explanation for degeneration was disputed the containment of the mentally deficient was seen as a lower priority. Mental deficiency services were located on a national agenda that had to respond to a succession of domestic issues during the interwar and post war years. During the interwar years the expenditure that was required to construct institutions was compared with the cost of providing working class housing. Similarly after World War Two the cost of providing specialised care was weighed against the resources that were required to extend universal welfare. When services for a minority group, such as the mentally deficient, were in competition for resources with services that represented the interests of a demographically larger group they did not fare so well.

When the fears about degeneration and a national disaster had subsided resources were directed towards other issues that were perceived to have a greater bearing on national interests. The implementation of the colony solution had been founded on a belief that economies of scale, coupled with the unwaged labor of the high-grade residents, would provide accommodation that was cheaper than any previous institutional design. When the Government was presented with evidence of the actual costs it was confronted with a dilemma that threatened to separate its commitment to the legislation and statutory provision that was already in place from the need to make adjustments in expenditure that suited the public's perception of the scale of the problem. Comparisons between the cost of developing colonies and the cost of working class housing revealed that the cost per person was higher in a colony. This revelation impelled the government to look for ways of reducing its expenditure on services during the interwar period.

Decision making at both national and local levels had to respond to change in a manner that was congruent with the exercise of power through democratic means. There was an expectation that the priorities expressed in policy and legislation, and the deployment of resources, would reflect the long-term interests of a majority of the population. The pressure on the government to respond to democratisation did not lead to the dismantling of services but it did encourage the providers of statutory services to look for ways of saving money by becoming more efficient, and by finding alternatives to institutional provision. The change in policy towards non-familial guardianship during the 1930s is an example of an area of social policy where earlier decisions had been revised in the light of economic pressures. Following the 1913 Act guardianship was intended to be the main form of community care. In the early stages families were not eligible guardians because it was envisaged that guardianship entailed the removal of the defective from a neglectful or corruptive home environment. A shortage of institutional accommodation and the scale of payments that would be required to establish a system of guardianship led to a reversal of this position so that by the 1930s parents were being subsidised as guardians. Thomson (1996, p.222) has calculated that this form of guardianship was a "cheap option" for the authorities. The cost of accommodation in an institution was between 24 shillings and 42 shillings; the latter sum would purchase a place in a small voluntary-run institution in the countryside. Guardianship provided through voluntary agencies cost between 15 shillings for females and £1 1 shilling for males, whereas placing defectives with their families cost 15 shillings per week.

In an earlier paper Thomson (1992) argued that many of the developments in community care during the interwar years took place in an atmosphere of stringent Treasury fiscality and pervasive cost cutting. He believes the extension of community care through voluntary groups showed that local authorities preferred to pursue options that would relieve them of the responsibility for providing accommodation, supervision and administrative support. Voluntary organizations had a ready-made administration and a supply of cheap "woman power". The cost saved to the local authorities

through voluntary work stimulated the early, rapid growth of community care but it also had some negative consequences. Voluntary groups were not present in every part of the country so the services that evolved were constrained by the availability of resources in each locality. As well as variations between different regions the use of voluntary or cheap labour allowed authorities to avoid investment in expensive training. When voluntary community carers began to professionalise they became employees of the local authorities, and the cost of their labor appeared to be disproportionately high. As professional status became established community carers became less attractive to local authorities but the lack of investment in training facilities capable of preparing employees with the requisite psychiatric expertise, meant that further growth was held back.

Changes in local government following the Local Government Act of 1930 led to a realignment of voluntary organizations, mental deficiency services and public health. The replacement of annual central grants with five-year block grants made the amount of money that was being devoted to voluntary organizations more obvious. Many local authorities responded by incorporating mental deficiency services into their public health departments. Locating the services in departments with a broader remit made them more susceptible to the dynamic of non-party politics at a local level. Thomson (1998, p.237) states that mental deficiency services occupied a comparatively low status area within councils. Decisions about provision were often subordinated to work that was related to issues with a higher public profile such as unemployment. The process of decision-making was often obscured by the work of more powerful committees and services. In an environment where mental deficiency services had to compete against more powerful services they were allocated resources that reflected their low status.

Developments in welfare and the introduction of the National Health Service continued to extend services towards sections of the population that had not been able to afford them previously. The election of a Conservative Government in 1951 was associated with a return to the significance of individualistic values and a movement away from the universalist model of

social policy. This movement was manifested in attempts to curtail public expenditure. Both Enoch Powell and Iaiin Macleod[2] claimed that the growth of statutory social services had led to a reduction in personal and familial responsibility. The multiplication of statutory services was aligned with high levels of taxation and disincentives to work. Paradoxically in 1956 the findings of the Gillebaud Committee[3] recommended that the Government should invest more money in health by engaging in a new hospital building programme. The Gillebaud Committee had been established to suggest areas for economy but evidence produced by Richard Titmuss and Brian Abel-Smith[4] showed that the NHS was taking a declining share of the GNP, lower even than the 1930s (Glennerster 1998, p.21). This led to an unlikely situation where Enoch Powell, who had publicised his concerns about public expenditure and high taxation, announced the largest hospital building programme since the Victorian era.

Professions involved in the delivery of statutory services e.g. the BMA, the Royal Colleges, teachers' unions and local authority associations, gathered support and established links with the large spending government departments. Consequently a succession of "expert" committees was appointed that produced evidence capable of winning support in Cabinet. In the late 1950s and 1960s there was a period of rapid expansion in higher education and massive investment in council houses, as well as reorganisation of the social work services and the National Health Service. Although many of these changes addressed the health and educational needs of a larger proportion of citizens the needs of minority groups were separated from the general interests of the rest of the population. Health services were focused on public health rather than groups with special needs. Psychiatric services

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[2] Iaiin Macleod was Minister of Health from 1952 – 1955 and Enoch Powell from 1960 – 1962.

[3] The Guillebaud Committee was set up in 1952 to investigate the cost of the National Health Service. It reported in 1956. See M. Hill *The Welfare State in Britain A Political History Since 1945* (Aldershot, 1999), 59.

[4] The Guillebaud Committee drew on the services of two advisors, Richard Titmuss (Professor of Social Administration at the London School of Economics) and Brian Abel Smith. See M. Hill *The Welfare State in Britain A Political History Since 1945* (Aldershot, 1999), 62.

placed greater emphasis on the curative services that would benefit more of the public, rather than services for the chronically sick or "incurable". The Royal Medico-Psychological Association in alliance with the medical profession consolidated their influence over the mental hospital system. In an area where resources were comparatively scarce the amount of money that was required to maintain hospital services prevented any additional investment in community care.

Hospitals to Community Based Care

The Ministry of Health's Hospital Plan in 1962 announced that some of the provision for the mentally ill and "subnormal" would be integrated into general hospitals. The overall aim of the plan was to reduce the number of beds in large, single purpose hospitals and provide more services in the community, or smaller medium and long stay units. Although there was some criticism of the plan to "run down" hospital provision the novelty of the proposals did not evoke as much skepticism as inquires about funding and resources. When Powell outlined the proposals during the NAMH conference in 1961 Titmuss expressed doubts about the Government's ability, or intention, of providing an adequate community service. His requests for acts of policy to verify that the Government was prepared to back up the rhetoric of community care with resources were not acknowledged. As Titmuss pointed out the level of government expenditure on community services had probably fallen over the 1950s, in 1960 it was less than the money that had been spent on compensation for fowl pest (cited in Thomson 1998, p.295). Goodwin (1989, p.33) has argued that in the mid 1950s the Royal Medico-Psychological Association expressed support for the idea of treatment in the community rather than community care. This led to more emphasis being placed on treatment services rather than caring services.

Concurrent with the expression of a commitment to community care was a progressive deterioration in the condition of institutions that had been constructed during the Victorian era. By the 1950s overcrowding had become a serious problem and many of the buildings were in need of substantial refurbishment. The quality of care available in institutions was declining

because they had not been maintained in a way that ensured their survival. Goodwin believed that institutions were allowed to atrophy so that money could be saved instead of being spent on the refurbishment of buildings that were deemed to be surplus to future requirements. Because funding from central government was not designated for the development of facilities for care in the community any savings created by running down the old asylums were retained by the Ministry of Health.

In opposition during the late 1960s the Conservatives returned to the themes they had delineated during the late 1940s and early 1950s. Once again they were critical of the demands that taxation made on the economy. The combination of plans for a more managerial structure in the N.H.S. and local government, together with reductions in long-term spending on housing and pensions, constituted a coherent selective strategy that laid the foundations for the politics of the Thatcher era (Glennerster 1998, p.22). Mittler (1979, p.12) had identified the division of responsibility between various departments at local and national levels as a major obstacle to progress during the 1970s. Problems created by a division of responsibility had been exacerbated by debates that had ensued over the nature of resource allocation and budgetary control. By encouraging the development of community services through a range of statutory, voluntary and charitable services resources had been dispersed between separate providers. The alternative to this strategy was to bring all of the services together in a single specialised service that would coordinate the deployment of resources between different providers. Although this would remove some of the barriers inhibiting the transfer of resources it would also abet the separation of services from mainstream services for the rest of the population. Mittler pointed out that this ran counter to the principle of encouraging people with learning disabilities to use community services so that they could receive the full benefits of citizenship.

Jones (1975, p.6) has stated that Tizard's 1964 study "Community Services for the Mentally Handicapped" and "Better Services for the Mentally Handicapped" presented a well-argued case for changes in administrative provision. Tizard argued for integrated community care in each area with a population of

100,000. The 1971 White Paper reiterated the case for medical services for the mentally handicapped becoming a part of the general medical services that were available in the community. Both proposals attempted to reduce the distinctions between institutional and community care. One of the aims was to allow people living at home and people living in institutions, whether they were run by the Hospital Service or by local authorities, to have access to the same services. Services included diagnostic and treatment facilities, schools, day centers, sheltered workshops and training centers.

Although the intention behind "Better Services for the Mentally Handicapped" was to remove some of the obstacles to more integrated services Jones (1975, p.159) has provided examples that demonstrate how the deployment of resources, and apportionment of financial responsibility, reinforced the divisions that separated Health Services and local authorities. One of the proposals in the White Paper was to increase the number of places in training centers so that they conformed to a uniform standard of 1.5 per thousand population. It also recommended the expansion of day places in training centers for adults coming by day from hospital. Jones suggests that the latter proposal commended itself to local authorities while the former received less support. Increasing the number of places available to people resident in hospitals was more appealing because the provision of places in training centers would limit the local authority's financial responsibility. Money that was spent on board and medical treatment for hospital residents would still be taken from Health Service funds. If the places were taken by people based in the community the local authority would have to assume financial responsibility for all payments, excluding Social Security payments.

One of the most intractable barriers preventing the movement of resources from institutional to community care was the proposal to transfer finances from central to local government. Local authorities had possessed the power to develop services using voluntary and statutory supervision under the 1913 Act. Their powers had expanded under the National Health Services Act, and the Community Care Plan of 1963. Although the intention to develop services had been expressed in policy local councils could not find the means, or the will, to

implement them. Jones (1975, p.14) has asserted that the provision of services for the "mentally handicapped" remained a low priority:

> Providing services for the mentally handicapped wins no votes, and may offend the ratepayers. The mentally handicapped command no power, and their pressure groups such as the National Society for the Parents of Mentally Handicapped Children, do not use conflict tactics. In the mind of many a local councilor, their priority rating is precisely nil.

Jones also believed that when the movement to reform services moved from central to local government it became fragmented and diversified. While the drive for change remained at a national level it sustained momentum. Fostering community care was a consistent aim of the 1974 Labour Government and successive conservative administrations but when policy was devolved to local areas it became less focused more susceptible to internecine squabbles.

Partnerships

Joint teams were established in an attempt to promote integrated services. Mittler (1974, p.14) described the instigation of joint planning, and joint funding to pay for it, as "the most important single development for mental handicap since the 1971 White Paper". Joint Consultative Committees (JCCs) and Joint Care Planning Teams (JCPTs) were set up to develop a framework that would bring the various service agencies together alongside consumers and their representatives. They were built on the alignment between the geographical boundaries of the N.H.S. and Local Government following the reorganization in 1974. One of the main aims of joint initiatives was to accelerate the process of de-institutionanlisation. Joint funding schemes created a mechanism that enabled Social Services Departments to obtain health authority money to instigate community care projects that would contribute to the hospital rundown programme, or provide support for people to remain in the community instead of seeking admission to hospital. Between 1978/9 and 1984/5 local authority provision (using health service funding) grew by about 7 per cent per annum. It continued to increase by around 5 per cent a year between 1984/5 and 1994/5. In 1994/5 joint finance and funding schemes funded by district

health authorities amounted to £211 million of gross expenditure (figures cited in Evandrou and Falkingnam 1998, p.205).

Joint funding enabled Social Services Departments to continue expanding provision at a time when there had been constraints on local authority budgets. To make this growth sustainable Social Services Departments needed to secure resources that would replace joint financing when it expired. The requisite level of resources would also need to keep up with demographic and other changes. This has made long term planning difficult. Local authorities have been reluctant to incur expenditure that would be difficult to maintain when joint financing was no longer available. Some local authorities saw it as a bribe to encourage expenditure to which they would not otherwise have agreed (Nocon, 1994). Malin (1999, p.17) believes that in spite of the financial incentives that encouraged joint planning most agencies have worked separately, and at best only in parallel with each other. Depicting a similar scenario Lindbolm (1965, 1979) has described the contrast between a service wide appreciation of users' needs, the accompanying acceptance of the interdependency of different agencies providing services, and the more parochial view of a single service provider or one of its subsections. He also identified limitations in a planning process that was restricted to those areas where there was a level of agreement between various providers. The process was characterised by incremental change, and the potential for independent decision makers to adapt to the decisions that were made around them instead of developing coherent strategies focused on long-term goals.

The Griffiths Report (DHSS, 1988) recognised the role of local authorities in providing community care. Instead of being a provider of care it argued that Social Services Departments should be involved in the design of care "packages" that would be delivered by the care market using a range of different "suppliers". Griffiths conceived the role of local authorities changing from provider to broker. By giving overall responsibility to Social Service Departments he believed that the management and co-ordination of services and funding would improve. Since the publication of Better Services for the Mentally Handicapped (DHSS, 1971) there has been a steady expansion of

community services for people with learning disabilities. There was an increase in the number of local authority provided residential care places up to the mid-1980s that remained steady in the late 1980s, and then declined in the 1990s. Following the implementation of the NHS and Community Care Act (1990a) there was a rapid increase in the number of people with learning disabilities receiving financial support from local authorities in residential care and nursing homes. In 1995 there were 22,700 people supported by local authorities, with an increasing number in places provided by the voluntary and private sectors (figures cited in Evandrou and Falkingham 1998, p.222). There was also a rise in the number of day care places. Between 1977 and 1992 the number of places rose form 38,900 to 56,700, an annual increase of 2.5 per cent (Evandrou and Falkingham 1998, p.222). During the same period there was a reduction in the number of hospital in-patients with learning disabilities. The number fell by 29,000 between 1984 and 11,000 in 1995. Similarly there has been a reduction in the number of in-patients under the care of a learning disability specialist and a rise in the number of community learning disability nurses from 770 to 2,020 between 1984 and 1994 (Evandrou and Falkingham 1998, p222). Evandrou and Falkingham (1998) were not convinced that this represented a net increase in the level of service provision for people with learning disabilities. The additional 7,100 local authority sponsored places provided in residential care and nursing homes between 1984 and 1995 were not sufficient to offset a fall in in-patients of 29,000 people.

Statutory Services and Informal Carers

As well as the discussions about financial responsibility there were also debates about the roles and responsibilities of different carers. Underlying many of the developments in community care policy had been an assumption that there was a significant role for public, private, and voluntary services in maintaining highly dependent people outside of institutions. During the 1980s a shortage of funds, and the Government's ideological commitment to a reduction in the role of the state in service provision, led to an adjustment in the roles that were envisaged for different providers. Greater emphasis was placed on families, networks or organisations assuming more responsibility for the dependent people living with them, or alongside them, in local communities. In

addition to enhancing the role that was ascribed to private, independent and voluntary providers, community care polices began to weave statutory formal care together with informal care. Policies alluded to the importance of supporting carers through "partnership" or complementing the role of the family (for example DHSS, 1986). Malin et al (1999, p.20) have pointed out that in the 1980s policies took family care for granted. Although it had been recognized that services for people living at home were a crucial aspect of successful community oriented care (DHSS, 1971) there was little evidence to suggest that policy makers acknowledged the full impact of the emotional, physical and financial costs that were being imposed on carers.

Social scientists conducting research on the gendered nature of caring have argued that in most cases responsibility for looking after dependent family members was delegated to female relatives (Finch and Groves 1983, Finch 1989). Means and Smith (1998, p.11) have reiterated the complaint of feminist critics of the welfare state who believe that the unwaged labour of women engaged in domestic and caring activities has been exploited by central government, and men in general. Similarly pressure groups that emerged during the 1980s joined together to form the Carers National Association so that they could draw attention to the importance of including carers in decisions that informed policy making. The House of Commons Select Committee report on community care, focusing on adults with mental health problems and learning difficulties, concluded that most people with special needs were already being cared for in the community by their families, mainly by women, and called for this fact to be recognized in policies (Social Services Committee, 1985). Subsequent community care legislation and policy, e.g. Caring for People (DOH, 1989), Community Care in the Next Decade and Beyond (DOH, 1990b), stipulated that informal carers and the users of services should have a greater say in how they lived their lives and the services that they needed in order to do so, although the mechanisms for achieving this were not prescribed within the documents. Malin et al (1999, p.43) state that Caring for People envisaged that they would be involved at both micro and macro levels. At the macro level service users and carers would be involved in the planning and

delivery of aspects of service. At the micro level it related to their role in identifying their needs, and choosing means for meeting them.

The informal care sector has been the largest provider of total care provision in private households. Calculations reflecting the value of informal care work have been produced to show the cost of replacing the unwaged work of carers with an average hourly rate of pay. Calculations have also been produced to indicate the opportunity costs of providing such support. Additional costs include career costs (i.e. disrupted labour market histories, lower earning related benefits and pensions as well as loss of disposable income), accommodation costs, and the cost of goods associated with service provision. In 1995 the cost of replacing carers' unwaged labour with an hourly rate of £7 (comparable to pay in the formal sector) was estimated at £35 billion. Government expenditure for the Personal Social Services amounted to £6.8 billion (i.e. expenditure constituted one fifth of the cost of family support). The opportunity costs of providing informal care were estimated to be about £17.7 billion for 1995, rising to £20.3 billion by the year 2031 (figures cited in Evandrou and Falkingham 1998, p.243). In addition individuals and private families spent £4.2 billion on private health care and contributions to statutory care services. This expenditure compares with around £7 million spent by Social Services Departments, £2.2 billion by the NHS, and £8.5 billion from the social security budget. The total cash cost of caring for elderly and vulnerable groups in the community amounted to around £22 billion in 1994/5 (Evandrou and Falkingham 1998, p.245). Specific figures on expenditure and costs related to informal care and people with learning disabilities were not available. However acknowledgment that most of the care received by people with learning disabilities in the community has been delivered by relatives in private households suggests that the dynamic is similar and the figures cited for care of the elderly and vulnerable groups have subsumed groups of people with learning disabilities.

During the 1980s the role of professionals involved in public sector welfare came under scrutiny while the Government was expressing criticism of the growth of public spending in proportion to the economy. From a Thatcherite

perspective professionals defending their status and resources were not responsive to market forces. They were perceived as an impediment to the advancement of the entrepreneurial and competitive society that was envisaged by the Prime Minister. The number of people employed in the public sector (local government, education and health) had started to expand in the 1930s, with a period of rapid expansion during the post war labour government's nationalization programme. Health showed a continuous rise from 2.1 per cent of the total work force in 1951 to 4.9 percent in 1981 (figures cited in Gladstone 1999, p.117). Since 1979 there has been a decline corresponding with the privatisation programme pursued by successive Conservative governments. The 1990s had introduced general management to the NHS and the benefits of "choice", consumerism, internal markets, purchasers and providers, were juxtaposed against the self-interest and arrogance attributed to professionals.

At the same time there were attempts to foster a greater sense of shared responsibility for policy and planning by involving the users of services and carers. Involving users and carers has revealed a level of contrariety between the needs and aspirations of different participants. The divergent interests of service users created some conflict. Although the disability movement represented the interests of a large number of people it has been argued (Means and Smith 1996, p.77) that it is able to articulate the views of people with some kinds of impairment and health problems more readily than others. Some "survivors" have expressed the view that the movement has placed too much emphasis on problems related to physical access instead of responding to the concerns of people with mental health problems. The capacity of the movement to represent all of the needs of the disabled population has been tested even more by some groups of people with learning disabilities, or dementia, where individuals have difficulties with communication and their participation in a service user movement may be impeded. As well as these constraints the movement has had to respond to criticism that has shown that the shared experience of disability has not provided an agenda that reflects other forms of oppression, for example those caused by age, gender, ethnicity and sexuality.

Assumptions about common interests uniting carers and people with learning disabilities have also led to difficulties. Although developments in community care for people with learning disabilities placed greater emphasis on them remaining with their families they had not offered carers any alternative to providing care at home. Critics have argued that community care has been favored because it reduces expenditure on paid staff, residential care and domiciliary support by substituting unpaid labour and the families' own material resources. A Department of Health study (1999a, p.14) found that although users and carers, particularly the latter, consistently emphasized the need to expand short term and respite provision it was not widely available. The report stated that just under 60 percent of people who lived with their families "were said not to have any form of regular respite care". A carer in Leeds has been cited in the report saying that such provision is "essential; (but) it's not available" (DOH 1999a, p.14).

Conclusion

This chapter has explored the changing role and function of services for people with learning disabilities. It has examined the emergence of the colony model during the early decades of the twentieth century. Colonies for "mental defectives" offered the purchasers and providers of services an opportunity to utilise the labour of high-grade inmates, and an incentive to save money through economies of scale. They also offered the purchasers of residential services and families the prospect of a segregated environment where care and control became the responsibility of paid staff. Although they did not provide the same level of professional contact and therapeutic intervention associated with psychiatric institutions they were an alternative to family care. The existence of an alternative reduced "tolerance" for disruptive behaviour in a domestic setting, and facilitated the expansion of an inspectorate that was charged with monitoring and regulating specialised services. Despite recommendations to expand provision from the Royal Commission (1908), and encouragement to develop "all-grade" institutions in the Wood Report (1929), funding to extend statutory provision was not abundant. This led to the

development of support systems that could be used to augment institutional care. Guardianship and supervision meant that care and control could be provided in the community through individuals and organisations on a voluntary or charitable basis.

Analysis of developments in the mid-twentieth century identified a range of factors that were influential in the movement towards deinstitutionalisation. Factors included a greater awareness of the complexity of social and economic problems that had been attributed to "mental deficiency". Psychological and sociological studies conducted in the 1950s and 1960s provided evidence of the detrimental impact of institutional environments (e.g. Clarke et al. 1958, Goffman 1962, Morris 1969). At the same time many of the buildings that were being used as long-stay hospitals had deteriorated to the extent that they required expensive refurbishment. The Hospital Plan (1962) envisaged a reduction in the number of hospital beds available for the mentally ill and "subnormal". The Plan entailed moving health service accommodation to designated beds in acute general wards, and a smaller number of medium and long stay units with secure accommodation. To improve the resources that were available in the community the Ministry of Health argued that local authorities needed to provide more hostels, training centers and social workers.

Health authorities were asked to describe how they were going to implement the Hospital Plan over a ten-year period. The 1971 White Paper "Better Services for the Mentally Handicapped" reinforced the proposal to transfer services from hospitals to the community. Although the intention to move services into the community was reiterated through the 1960s and 1970s, as well as the 1980s and 1990s, the transfer of resources and responsibilities was spasmodic. Analysis of the material in this chapter has shown that a gap separated the rhetoric of community care from the reality of provision in the community. The gap had been caused by disparity between the intentions expressed in policy and the allocation of resources to implement them at a local level. In addition rhetoric surrounding the benefits of "joint planning", "joint funding" and multi-professional work concealed some of the tensions that emerged between the different agencies responsible for commissioning, and

providing services. Material in this chapter has examined how funding for learning disability community services exacerbated divisions between providers of health and social care. The chapter has also explored tensions created by successive Governments that have made a commitment to expanding community services while they have espoused the language of curtailment and containment regarding welfare spending.

Although community care in the late twentieth century has emerged in the context of policy documents that were implemented to promote change there are elements of continuity that link the mixed economy of the 1980s and 1990s with the range of service providers at the beginning of the century. While funding for statutory provision had been subject to strict financial control from central government private sector accommodation increased in the 1980s through a combination of public funds and private ownership. This combination was similar to the partnership that developed between the Home Office and Harold Burden while Stoke Park grew from an industrial school to a colony. Although both health and social services are major contributors to statutory provision at the end of the century the mixed economy has also relied on significant contributions from the independent, charitable and voluntary sectors. Fragmentation has occurred where specialised services have been integrated and subsumed in mainstream or generic services (e.g. services focussed on health, education, employment). This development is analogous to the situation at the start of the century when the needs of people with learning disabilities were less visible because they had been "submerged" within other groups.

The emergence of community care in 1970s, 1980s and 1990s has had a profound impact on the roles of professionals working in the services. Plans to close long stay hospitals have meant that they have not been the nucleus for other services. Learning Disability Nurses that had been involved in residential work in hospital wards have had to adapt their working practices so that they can support people with learning disabilities in homes and hostels. Conversely doctors, nurses and other professionals working in primary care services have had more contact with people with learning disabilities as they have moved out

of secluded hospitals. The roles of professionals delivering social services have also been transformed. Since the Griffiths Report (DHSS, 1988) recognized Social Services Departments as the lead agency for brokering services they have been involved with monitoring and purchasing services as well as providing them. The most significant development in the late twentieth century has been an increase in the number of carers that have no formal training or preparation for their work, and the use of informal carers. Both the health and social services employ unqualified staff to deliver care. Many private, independent and charitable organisations also use unqualified staff to provide care for people with learning disabilities. The family has always provided the locus of care in the community but at the end of the twentieth century policies have been focussed on the contribution from informal carers to the extent that care in the community has become synonymous with care provided by the community.

Chapters 6 and 7 will look at the perceptions of learning disability nurses in more detail. Material has been derived from interviews with qualified nurses and care assistants that were working (or had worked) at Stoke Park. The interviews were recorded while hospital staff were preparing to close wards and move into the community. The material includes some of their reflections on the transition from hospital to community care.

Chapter 6

Stoke Park 1960 - 1997

The following chapters were derived from a combination of interviews and documentary material. All of the interviewees had worked at Stoke Park. Some of the interviews were recorded with members of staff while they were working in the hospital. During the period in which the interviews were recorded wards were being closed and the closure of the site was imminent. In the course of the interviews members of the hospital staff frequently referred to the changes that were occurring around them, and the changes that lay ahead. Their responses include hopes, expectations and anxieties as well as comments that relate to more concrete experiences. Most of the interviewees saw the closure of the hospital as a significant landmark in their work. The concept of the community care and the practical preparations for the moving out provided interviewees with an opportunity to reflect on the differences, or similarities, between their work in a hospital environment and working in the community. Inquiring about the changes that would affect their jobs in the future, or asking whether they felt optimistic or pessimistic, gave them an opportunity to talk about the past, as well as predicting what may or may not happen to them when they moved out. Interviewees often used the question about "quality of life" to talk about the impact of the services on the lives of the residents. Descriptions of how their lives would change when they moved, listing the things that they would be able to do, and the things that they were less likely to do, provided useful images of life in the hospital as well as the sort of lives respondents believed the residents were going to lead outside.

Interviews with staff that had moved away provided a different standpoint. Respondents were able to provide concrete details about their experiences in the community as well as recalling incidents from the time they had spent in the hospital. Many of them were able to compare and contrast their expectations of community care with their practical experiences in community homes. To make it clear which interviews were conducted in hospital wards, and which took place in community homes, each extract from an interview has been denoted

either "C" or "H". A "C" in the bracket underneath the extract means that the interview was conducted in a community home. It has been followed by the identification of a specific home i.e. Home 1 or Home 2, the role of the interviewee e.g. Care Assistant, and finally the identity of specific interviewees e.g. Care Assistant 1, Care Assistant 2 etc. An "H" in the bracket underneath the extract means that the interview was conducted in the hospital. It has been followed by the identification of a specific ward i.e. Ward 1, Ward 2 or Ward 3, the role of the interviewee e.g. Staff Nurse, and finally the identity of specific interviewees e.g. Staff Nurse 1, Staff Nurse 2.

When the interviews were recorded the concept of providing residential accommodation in the community was changing. The notion of moving from the hospital into a small group home for four to six people was no longer viable because the money that had been used to establish the first wave of houses had been exhausted. In an interview for local television Pamela Charlwood (Chief Executive, Avon Area Health Authority) expressed a sense of personal frustration about the failure to replace the hospital wards at Stoke Park with small group homes:

> I acknowledge a great sense of personal frustration at that, having ten to fifteen years ago myself being part of the movement which started off from saying this is about 4 and 5 bedroom houses. But there is no way now with the changes. That was when we were drawing on Social Security money flowing like an ever-open tap. The tap has been shut off now. The taxpayer simply can not afford to keep on seeing that money flowing out in ever-increasing amounts. And that's all therefore about compromises. But I genuinely believe that by the year 2000 we will see everybody better accommodated than they are today.
> (Close Up West, 1997)

The alternative to small group homes was larger residential units. Because of their size some staff had started to question the benefits of moving away from the hospital to live and work in buildings that resembled the wards they were leaving behind. Others saw the move as a step towards equality because it symbolized the end of segregation, and the change of location put the residents in a better position to gain access to the services that were available to the rest of the community. The interviews gave staff in the homes an opportunity to

express their views on the advantages and disadvantages of community care at a time when they were having to adjust to the sort of compromises that Pamela Charlwood has described.

As well as the interviews these chapters have included documentary evidence. This evidence has been used to integrate themes from the previous chapters with the interview material. Although some interviewees were able to remember a time when the hospital was larger and busier, their memories had been shaped by the wards that they had worked on and the residents they knew. In some interviews staff accepted what they saw around them as the "norm" and the past was a matter for conjecture. It was difficult for these interviewees to use descriptive terms that measured progress or a decline in standards because they did not have a clear impression of any events that had preceded them. Documentary evidence has been used in these chapters to give an impression of services at Stoke Park between the 1960s and the 1990s, and to illustrate the process of continuity and change. Evidence from newspaper and television reports has also provided a view of the hospital from the "outside". Some of the reports from the local press convey a sense of shock and surprise that suggest how people from outside the services may have responded to conditions in Stoke Park. Press reports have also provided a record of incidents such as visits to the hospital by Richard Crossman (Social Services Minister) and Kenneth Robinson (Minister of Health) that had not been alluded to in any of the interviews. The material shows that the hospital has received attention from the local and national media during its' history.

During the interviews staff rarely referred to the signs and symptoms associated with a specific syndrome. Diagnosis was not a significant feature in descriptions of their work with individuals or groups. When reference was made to a particular behavior the interviewee tended to attribute causes to environmental factors rather than syndromes. Similarly peoples' status under the Mental Health Act was not a characteristic that interviewees used to define or delineate the people they worked with. Most people talked about their work in terms of their relationships with individuals and the environment of the home, ward or hospital. They used the terms "service users" and "residents" most

frequently. Both of these terms were used to describe people living in the community and the hospital. Although the terms were used to describe both locations the words were also used to convey their impressions of the services in different periods. Interviewees often described the services that existed twenty years ago using the current terminology, although some people would introduce archaic terms alongside the current terms to show that "service users" and "residents" had been referred to differently in the past.

During the interviews members of staff showed that they were acutely aware of the prevailing direction of social policy. The conceptual link that connected all of the material was the interviewees' thoughts and observations on the movement between hospital and the community. They regarded the closure of the Stoke Park as the final stage in a lengthy process of deinstitutionalisation. Some of the staff were able to recall details about the different phases that they had been involved with e.g. a period when Ward Sisters and Charge Nurses were encouraged to change the interior decor and create smaller areas using partitions to counter the "institutional" appearance of wards and cultivate a more homely environment in the hospital. The staff that had worked on the site for two years or more could remember when the groups on wards were larger. Some of the interviewees were working in buildings that had been subdivided to make smaller "flats" but they could remember when the buildings had been single wards accommodating forty people.

Interviewees recognised that the number of residents and the resources available on site were diminishing. At the same time they perceived the community as an area where services had expanded and money had been invested. Interviewees talked about the hospital and the community as geographical spaces but they also referred to them as conceptual spaces. They would discuss the deployment of resources between the two areas and the ways in which the different environments would influence the behavior of staff and residents. These discussions incorporated their thoughts on the rates of egression from hospital for different groups and any factors that would promote or impede their integration into the community. Nearly all the interviewees were able to describe some benefits that they associated with the

provision of community care. Many of them described a mixture of gains and losses where the positive aspects of life in the community were weighed against the negative consequences of losing the facilities at Stoke Park.

Qualified and unqualified staff gave the impression that they believed the quality of care had improved throughout the services, and that some of these improvements were not dependent on the location of services. They referred to practices such as Individual Planned Care (IPP), the promotion of independence, and joint decision making, as ideas and actions that had broken down the legacy of "block treatment". Although a shortage of staff on a ward, or in a home, could precipitate a decline in standards most people talked about delivering care that would provide a quality of life that was comparable to "everybody else's". A lot of the staff expressed an ideological commitment of this nature. The values they espoused emphasized the importance of individuality rather than saving money, time, or effort, through practices like block treatment.

Stoke Park 1960 - 1990

Stoke Park had been a focus for attention in the local and national press during the late 1960s and early 1970s. An article in the Western Daily Press (25/9/69) under the headline "Shame of the sordid wards" included a quotation describing conditions in Britain's homes for the "mentally subnormal" (sic) as "Grotesque, Dickensian, appalling". Both the Western Daily Press and Bristol's Evening Post carried reports on visits from Richard Crossman (Evening Post 3/11/1969) and Kenneth Robinson (Western Daily Press 5/11/1969) when they came to the hospital. The Hospital Management Committee had asked Mr. Crossman[1] to visit and comment on "deficiencies" in three aspects of the hospital service including meeting the needs of patients, staff shortages and overcrowding (Western Daily Press 5/10/1969). Following Mr. Crossman's visit Arthur Browning (Treasurer, Stoke Park Hospital) had called for a full investigation into mental subnormality services involving the local authority (Bristol Corporation),

[1] For more information on Crossman see the footnote in Chapter 5, p. 136.

the Regional Hospital Board and the Health Ministry. During the interview he called for a full investigation on the one hand and a slum clearance programme on the other". He had stated that "We must be able to house our patients in better conditions. We cannot go on like this" (Western Daily Press 25/9/1969).

The 1972 documentary on Stoke Park produced by the British Broadcasting Corporation (BBC) contained interviews with Charge Nurses Glyn Evans and Vic Poegal. Glyn Evans described what it was like in the Day Room on his ward. Sixty people would assemble in the room to watch television. Residents that could not get near to the television set had to mill about in the dining room, or go to bed, because there was nowhere else for them to go. The overcrowding and lack of stimulation often led to outbreaks of violence and damage to the building:

> Quite a bit of violence. One patient will upset another one, eventually you get about six or seven of them are fighting. Then you get all the sort of things like broken windows all around the place. This is where they give vent to their feelings.
> (Update: Situation Subnormal?, 1983)

Although the hospital provided accommodation for people with multiple disabilities it did not provide any special facilities for them. During the interview Glyn Evans indicated a room that was adjacent to the day room.

> They live in that room all those crippled patients; they are all wheelchair patients. They live in that room, they eat there, they sleep there. Some of the more spastic type patients - we do soap enemas on them twice a week. That's done in there and all the water is carried in buckets.
> (Update: Situation Subnormal?, 1983)

Vic Poegal described a similar lack of resources on Ivy Ward. In his interview he stated that there were one hundred and five patients on the ward but only sufficient chairs for forty-one. He thought that the ward could accommodate fifty people safely. The risks from overcrowding, particularly the risk of fires at night when the staffing level was minimal, led him to believe that the building should be "pulled down".

Following an investigation and a report produced by the Hospital Advisory Board the hospital received some money to make improvements at Stoke Park and Purdown. An article providing details of the improvements appeared in The Sunday Times (16/4/72) produced by HW White (Secretary, South-Western Regional Hospital Board). The article stated:

> Schemes completed since 1970 include the provision of 150 beds in new purpose built units at Stoke Park Hospital - costing nearly £400 000 - and which the advisory team stated as good as any they had seen.
>
> To relieve some of the overcrowding at Purdown Hospital new ward units providing 60 beds have already been erected and further units totaling 120 beds are now being planned at the Stoke Park and Purdown Hospitals.
>
> The up-grading of some of the existing wards at Purdown Hospital has also been undertaken at a cost of nearly £90 000 together with lifts, new workshops for patient training and improvements to engineering services. Extensions to the occupational and industrial therapy facilities should be completed this year.
>
> In total the capital expenditure over the past three to four years for the Stoke Park and Purdown Hospitals has amounted to approximately £650 000.
>
> In addition the Board has, since 1969, increased the annual financial allocation to meet the day to day expenses of the Hospital by more than £300 000 pre annum.

The figures cited by the Secretary were not comparable with a two million pound rebuilding plan that had been submitted to Health Secretary Keith Joseph. An article in the Western Daily Press (10/4/1972) stated that Sir Keith had been in possession of the confidential report produced by the Hospital Advisory Service for nine months. In spite of the increases in expenditure the article declared that "little progress had been made towards improvement in the city's most overcrowded hospitals" and doctors and officials feared that the rebuilding plan had been abandoned.

During 1983 the BBC made another documentary at Stoke Park to report on developments in the hospital. In the period between 1972 and 1983 more

money had been spent on improvements. Alan Heaton-Ward (Consultant Psychiatrist) said that:

> We have certainly moved on a long way since 1971. There is a lot of improvement in the accommodation. The total number of patients has been reduced so that the units are smaller. They are very much more homely. A lot of money has been spent. The unnecessary admission of patients has been stopped since then. Still I think that occasionally patients have to come in because there is nowhere else for them to go. Certainly it's been a much more specific role that the hospital has had to play.
>
> (Update: Situation Subnormal?, 1983)

When money had been available it had been used to address the most pressing problems in the hospital. These stemmed from overcrowding and the deteriorating fabric of the older buildings. The solutions that Heaton-Ward described included a slum clearance programme, refurbishment, and the construction of some new, smaller wards. Attempts to reduce the numbers of people in hospital were achieved through restrictions on admissions e.g. restrictions on the admittance of children to hospital. Even though expenditure in the hospital was limited to the most urgent problems it was not accompanied by any strategy to bolster investment in community services. It was envisaged that the hospital would continue to be used as a base for specialised services e.g. respite care. Money had been spent so that the deterioration of the existing buildings was slowed down and overcrowding on the most heavily occupied wards was alleviated. These steps were intended to maintain the services on site, thus prolonging the life of the hospital. The impression that has been created is in accord with Welshman's contention (1999) that the rhetoric surrounding community care developed at a pace that left the "reality" of provision a long way behind.

The new wards had been constructed to accommodate smaller groups. The division of the large wards, combined with "modern" interiors, exerted a positive influence on the behavior of the residents. Jackie Coombes, Ward Sister on one of the new wards, said that the incidence of behavior problems was "minimal, compared to what they used to be" and levels of aggression were

"much less". She identified improvements in the living accommodation that had played an important part in changing patterns of behavior:

> There's just twice as much room. They have got a lot more privacy. They can shut themselves away if they want to, whereas before there was just one great, long room. They just couldn't get away from anybody.
> (Update: Situation Subnormal?, 1983)

She also described how smaller groups had facilitated changes in nursing practice. Smaller groups, and an improved staff ratio, allowed the nurses to direct their efforts towards engaging residents in different activities, and encouraging them to participate in daily events. Her impression was that the quality of the residents' lives had improved because "They behave better and they participate in things they never participated in before".

David Miles, a Charge Nurse on one of the new wards, thought that the residents were "happier" than they had been before. He concluded that one of the factors contributing towards their happiness was more involvement in "ordinary, day to day, practical experiences". He believed that practices in the hospital had changed so that the residents were able "to participate more in their own day". Although the environment had improved he maintained that conditions in the hospital were not on a par with "ordinary" homes:

> People might see these new buildings on film and think that they have got lovely living conditions but all they are getting is what we would expect for ourselves, in our own homes. And there is 24 of them, and they are still sharing. They have to share each other's company 24 hours a day. They have got to share the same facilities all of the time. And to be individuals is very difficult when you are sharing with 24 other people.
> (Update: Situation Subnormal?, 1983)

In addition to measures that had been introduced to combat overcrowding, and the institutional appearance of wards, nurses also described changes in the structure and delivery of care. Staff talked about the importance of protecting peoples' individuality and encouraging their participation in everyday events. The dynamic shaping nursing care in the hospital had changed so that the containment of large groups, and "production line" practices that had

accompanied block treatment were countered by assertions that emphasized the importance of individual choice, privacy and dignity.

Not all of the residents on the newer wards had rooms of their own, or shared a double bedroom. Some of the wards had a few single and double rooms but many of the residents spent most of their time in large communal areas:

> This ward had been built about ten years now, and as you can see the area that we are standing in at the moment comprises of a very large sleeping area. This ward in fact has 26 beds; the other 4 beds are in single rooms. Well obviously they are living and sleeping in close proximity, and naturally sometimes people don't get on with each other, and as you can imagine if you have got 22 people living so close to each other, sometimes little arguments are going to develop which obviously wouldn't occur if they were living in smaller environments.
> (Phil Harrison, Charge Nurse, Update: Situation Subnormal?, 1983)

The program of incremental closure, building, gradual renovation and refurbishment meant that the wards were not able to provide accommodation of a similar quality. Progress towards small bedrooms and living areas was uneven. Sometimes it involved the gradual subdivision of wards into groups that could be accommodated in a flat or shared room. One of the Care Assistants that was interviewed in 1996 worked in a flat with some larger, shared bedrooms, but she could remember when a bedroom on the same ward contained five or six people. She thought that the rooms were better than before:

> They are nicer 'cause at one time they used to have, lets see now, I'm not denying that there ain't a few of them in one bedroom but at one time they used to have say six, seven resident in one room and not much space to walk about, not nice furniture. But now comparing to today, life of living, it's better than it was.
> (H. Ward 1, Care Assistant 1)

In the hospital the division of wards into separate flats was regarded as an improvement on the "open plan" structure, and large communal areas. One of the Staff Nurses that was interviewed stated that eight people in a flat was a "nice" group to work with:

On the flat I'm on now there's actually eight people. Altogether there's twenty-one residents and we've got a couple of people that come in for respite care. I think to be honest I prefer .... I think it's nice having a flat system in a way because I'm actually Flat Leader down in Flat One. I think it's nice because you have got less people to actually be responsible for say, the individual care. I think it's a lot easier. Because I always liked it on Katherine Burden before I came down here. They had two sort of flats there so I think it does work out quite well. Because obviously you have got the overall manager, and then you've got several qualified in charge of each of the flats and it does make it easier.

(H. Ward 1, Staff Nurse 1)

Dividing the ward into flats had changed the managerial structure, the ratio of staff to residents, and the administration of care, as well as reducing the size of groups. The interviewee believed that it was the combination of these changes that had made "individual care" possible.

Breaking down the large open plan wards had encouraged nursing staff to take on the responsibility for planning and delivering individualized care to the groups in each "flat". The concept of individualized care incorporated measures to create less "impersonal" surroundings and attempts to protect residents' privacy. A Staff Nurse that had moved away to work in the community remembered that her attempts to create a more homely atmosphere seemed like a struggle "against all odds":

- It used to be like trying to make it into a homely environment against all odds before. We used to section areas off pretending that it was a living area, and stuff like that, with the aid of a screen, and trying to sort of curtain people off so that they had a bit more privacy. Trying to make the best of a bad job, and taking people out all the time - it was just silly.
(C. Home 1, Assistant Home Manager 1)

Incorporating elements from normalisation (Wolfensberger and Glenn 1975, O' Brien and Tyne 1981), social role valorisation (Wolfensberger, 1984), and the service accomplishments described by O'Brien (in Bellamy and Wilcox, 1987) into practice had encouraged nursing staff to create a more domestic setting for services. In addition the practice of setting individual goals involving the enhancement of "community presence" and "community participation" had encouraged the staff to take residents out so that they could gain more

experience in the local community. Looking at these activities retrospectively had made the interviewee describe them as "silly" but the description of her actions in the past would suggest that day trips and visits were the only ways that service users were able to assert their presence in the community while they were resident in the hospital.

A Staff Nurse that had remained at Stoke Park described the transformation of the wards in a more positive way. She had left the ward where she was interviewed, and then returned to it after working in a different part of the hospital. During her absence the arrangement of bedrooms and dormitories had been improved:

> They were two dormitories and three or four side rooms. And that was for some of the guys that were quite noisy that needed somewhere quiet for them to go and a bit of peace and quiet for the other blokes. There was one chap who used to scream constantly and he would keep everybody else awake if he was in the other dormitory. I think there were about seven in each of the dormitories and the three or four side rooms. Having gone back it was all partitioned off and they all had curtains. There was none of that before. When I went back in there in 1990 it had all been nicely updated.
> (H. Ward 2, Staff Nurse 1)

She saw improvements in the decor and arrangement of the ward as signs that indicated slow but steady progress. Some of the staff saw the move into a community home as another step that would lead to improvements in the residents' material conditions. A Staff Nurse that was moving with a group of residents from the flat that she worked on thought that the move was beneficial because it would provide people with individual bedrooms. The interviewee described their new home as being "very similar" to the present one. It comprised a single building divided into two flats, however, the division of space in the flats enabled all of the residents to have their own rooms. The interviewee saw the provision of separate rooms as a significant achievement. A Care Assistant that was preparing to move with the same group expressed similar views:

> One good thing about us going is they will all have their own bedrooms. I always think that they should have their own rooms for a start. Because it just gives them a tiny bit of independence and some of the residents constantly make noise all night long, which keeps other people up. If they have got their own rooms there's a lot more privacy and stuff like that.
> (H. Ward 1, Care Assistant 2)

The provision of individual bedrooms enabled the occupants to attain more privacy and personal space. Using small bedrooms rather than large dormitories had also made it possible to accommodate mixed groups of men and women in the same flat instead of single sex groups.

Streaming and Classification

During the interviews the majority of respondents did not make any overt references to an organizational or administrative scheme that had been used to construct groups of residents in wards or homes. While they made no overt references to a scheme or document they frequently used terms that suggested there was a hierarchy. They often described how people with similar abilities or needs were brought together on the same ward, or in the same house. When some of the interviewees described their earliest experiences in the hospital they referred to wards with "high grade" or "low grade" patients, others would refer to wards for "more able" or "less able" residents. Interviewees also talked about wards where most of the residents were "disabled" or "in wheelchairs". Some of the terms described groups that no longer existed. These groups had been separated or merged within other groups as individuals were moved to other wards, or hospitals, or into the community. On occasions interviewees identified a resident on a ward that they had known for a long time. They would describe the person using their previous residence as a point of reference for example, she was one of the original residents from the Firs, or "he was one of the old Limes residents". Although the person had arrived at their present ward or home after they had been separated from this group they still retained an association with their former ward through the label that bonded their former residence with their personal identity.

Changing Wards

Analysis of the content of the interviews revealed that various labels denoting wards or abilities still had currency as historical markers, and as a way of explaining the dispersal of people between wards and community homes within the health or community care trusts. In their descriptions of the hospital interviewees would refer to the occupancy of wards, or their closure, to differentiate between periods and levels of activity. The Staff Nurse in the following interview used the opening and closure of wards to explain why there were not as many residents moving around the hospital as their had been when she was a Pupil Nurse in the 1980s:

> Loads and loads of people always milling around. Because all of the wards, Clifton was open, and Wells and Plymouth and Exeter. They were all open. Those wards are closed now along with Lincoln and Canterbury. Just how busy it was. There was lots of people whereas now you don't see many people at all in comparison. Because the wards that are left generally, either here or Gloucester House, are challenging behavior. You don't see these people out very often, or the elderly wards, or the physically handicapped. You see very few people around these days, which is a shame.
>
> (H. Ward 2, Staff Nurse 2)

Her description began with a list of wards that had been open when she started working at Stoke Park. As the wards closed, and the number of residents decreased, the site did not appear to be as "busy" as it had been in the past. She goes on to say that the closure of wards was not the only reason for the decline in activity. Her explanation links a reduction in numbers with the type of wards that remained open. The remaining wards were designated for people with challenging behavior, physical handicaps and the elderly. The hospital had become a base for these groups when the previous occupants of wards like Exeter and Wells, or Lincoln and Canterbury had moved away. Because the remaining residents tended to stay on the wards it created the impression that there were "very few people around".

The hospital population had been reduced in the decade between 1980 and 1990. While some of the people with less severe disabilities had moved into group homes in NHS and community care trusts the people that remained in

hospital were put into groups with people that shared common characteristics e.g. their age, physical impairment or behavior. Wards were also referred to as accommodation specifically for people with challenging behavior, or multiple impairments. Interviewees would also refer to a variety of strategies that had been used to combine or separate different groups in the past. A Care Assistant (H. Ward 1, Care Assistant 1) that had been working in the hospital for more than fifteen years remembered a time when the ward was larger and the age range of the residents was broader. When the interview took place she was working in a "flat" on a ward. The flat was for eight people but she could remember when the ward had forty residents. Residents had included children that attended The Poplars school (on site) and adults in there thirties and forties. She described the people on the ward as "disabled" and her work included "washing and dressing for most of them. There was only a few that could feed themselves".

The description of a ward in which children and adults lived alongside one another was unusual. On the other wards they had been separated. Using the same area for children and adults appears to have been limited to the wards that accommodated people with multiple impairments. It was probable that the mixture of people with different ages was necessary because the modifications that were needed to make the lives of multiply impaired people safer and more comfortable were available on one or two wards. The other wards lacked any specialised provision for multiply disabled adults or children. A Staff Nurse (H. Ward 1, Staff Nurse 2) that had been working in the hospital for more than ten years recalled that when she worked with children they were on a separate ward that combined child care with respite care. She recollected that the children on the ward "ranged from about two" upwards. The presence, or absence, of facilities for children in the hospital was a significant landmark in people's memory. Although there was physical evidence of provision for them on the site, such as the presence of swings and roundabouts, children had been the first "group" to leave the hospital.

In 1983 Shirley Barrington (Ward Sister) described how the ward that she had been working on was split so that she was left with a group of 19 children,

rather than a group of 30. The children lived on site and attended The Poplars. She believed that because of their impairments the children that had remained on the ward would need to be in the hospital "for the rest of their lives". When the interview was recorded a policy deterring the admission of children had been in operation for some time. Although the number of children in the hospital had been reduced she said that it still had a role to perform:

> The last child we admitted was about five years ago. It doesn't mean that because we haven't admitted during the time of five years that there is no need for us. It is because community care is the in thing now and we are here really to help all those mums and dads out there who have got their children at home.
> (Update: Situation Subnormal?, 1983)

She described the hospital as a site for services that would run alongside community care instead of becoming obsolete or unnecessary. Children were not admitted but they still made use of services on site, such as the provision of respite care. The image that has been conveyed suggests that her conception of community care and hospital provision were not mutually exclusive. Even though community care was the "in thing" she believed that there were children that would need hospital care throughout their lives. The availability of services outside the hospital meant that help for parents who kept their children at home was available through the hospital, rather than services in the community.

In the years approaching closure Stoke Park and Hanham Hall were used to provide accommodation for the more elderly residents in the Trust. The need to consider the position of a large group of elderly people was a sign that the residents were living longer lives and that the type of accommodation that suited them was in short supply. When it was time for Stoke Park to close the existence of a large group of elderly people was used as a rationale for keeping Hanham Hall open. Although it was seen as a compromise that was contrary to the movement of services into the community, Pamela Charlwood believed that the proposal had gained support because it suited those residents who did not want to move away from a hospital environment, and it was economical:

> There are some residents at Hanham who are over 90, for those individuals it might well be sensible not to try and move them, and

> disrupt them from a site and situation that they know about, and that they feel comfortable and confident in. But I suggest that we would probably look to it as being limited life accommodation so that when that older age group of residents eventually die themselves, perhaps over the next ten years, you would say "Right, now we will close down these buildings as well". Five years ago I would not have expected to have had to think about compromise but I think we may have to look at that as something that is affordable.
> (Close Up West, 1997)

She conceded that deferring the closure of the hospital was a compromise but it marked another transitional phase in the movement towards community care. The final stage would be prescribed by the longevity of some of the residents, together with the cost of providing alternative accommodation.

Some of the staff referred to various arrangements for separating men and women into different groups; sometimes they involved using other sites in the Stoke Park Group, on other occasions it was separate wards on the same site:

> I started in 1972 as a Cadet (pre-nursing). The wards were very large. Thirty plus. They was either adults or children. If I remember correctly it was mainly females at Stoke Park; and the men were either at Purdown or Hanham. There was York Ward and Gloucester here, which were mainly for the Children's' Wards as they were known then. York being the more multiple handicapped. And Gloucester. they had two areas; A and B. Gloucester B was the more physically handicapped the A were the more able.
> (H. Ward 1, Staff Nurse 3)

This interviewee reinforced other references that had been made to wards that had been designated "more able wards", "multiply handicapped wards", and "children's wards". She recollected that the age of a resident on an adult ward could be anywhere in the range from seventeen to sixty (or beyond). She also recalled a time when men were sent to either Hanham or Purdown. Many of the interviewees had started their work in the hospital when the population contained males and females, divided into single sex groups.

A member of staff that had undertaken her training at Stoke Park described how she had worked with an all male group on Bristol Ward:

> The first ward I actually went on - I think it was Bristol Ward and there was a lot more numbers on there and there was a lot more men. And I think as much as you try sometimes, it wasn't geared to the individual. But now I think the wards have got smaller and it's geared a lot more towards that but because of the numbers it was a lot harder to give individual care. Whereas say with IPPs its more possible to do that.
> (H. Ward 1, Staff Nurse 1)

Like many of the interviewees she commented on a reduction in the number of people living on the ward. Smaller wards were frequently linked with the provision of "individual care" but this interviewee also mentioned the implementation of a system of care that produced IPPs. When interviewees described changes that had led to improvements in the standard of care they were attributed to a combination of factors. The reduction in numbers was seen as the most significant change. This was accompanied by a reconfiguration of the groups on each ward to accommodate a smaller number of residents. Many of the staff thought that creating a more homely environment had been another important factor. Amongst the qualified staff interviewees also referred to changes in nursing practice, and the conceptual framework that supported care. Focusing on the assessment of each resident's strengths and needs, and the creation of IPPs, had enabled staff to counter "old school" practices where recognition of individual needs had been lost in the institutional regime. Practices that promoted individuality were used as an ideological bulwark against the pressures that had led to "task orientation" and "block treatment" in the past.

Compatibility

Opinions were divided on the advantages and disadvantages of streaming people and putting them into groups according to their abilities. When Staff Nurse 2 referred to the system that had operated in the past he described the advantages of constructing groups using the labels "high-grade" and "low-grade". In the period he was referring to the hospital contained residents with a wider range of abilities. The presence of people that he has described as "high-grade" made it possible to give some of the residents jobs around the hospital. In the context of the interview the labels that he has applied to

residents indicate their status within the hospital as well as their level of competence:

> It was not cross-matched. In fact it was highly selective. You got sensory handicapped residents on one ward; you could have low-grade on the other ward. Where even higher-grade people, as you call it, were helping out all the younger ones to reach more independent decisions. In fact it was well matched. It was much more self-sufficiency in terms of the residents' occupation then. It benefited them and matched them in terms of the staffs' characters and personalities. Every ward was appropriately placed to meet their own needs. In fact needs were defined according to fairly strict criteria for high-grades and low-grades and medium. Each ward was defined according to what was appropriate. If you were looking at a low-grade ward they had all shades of similarity in patterns of behavior. In a high-grade ward they all had responsibilities to the extent that they became additional members of staff. They had gardeners, they help out with shops, in the Occupational Therapy Department. Unlike now they help the staff in feeding programs, they help staff with the laundry, and they were paid reward money. And most of the clients that I know, who are successful in the community, because they had been long term in hospital, institutionalized, but they still benefited a lot from that period of time. (H. Ward 2, Staff Nurse 2)

The hospital brought people with different abilities together on one site. Although some of the "high-grade" residents were able to work their individual needs and capabilities were submerged in the cumulative needs of the less able residents. Their skills were viewed as a way of making the hospital "self-sufficient" rather than making the more capable individuals independent. While this interviewee believed that the existence of a grading system had helped to create a balanced environment there were other nurses that believed the same system had been responsible for creating a bad atmosphere on the wards. Staff Nurse believed that it was advantageous for people with similar abilities, or behaviour, to live together. While it may have been beneficial for some of the people that enjoyed the status of "high-grade" residents to live together it was likely to have a detrimental effect on the people that were labelled as "low-grade". As a consequence of grading residents with challenging behaviours or multiple disabilities were moved to wards where people with similar characteristics surrounded them.

Staff Nurse 2 stated that these characteristics were not synonymous with compatibility:

> They are not compatible. I mean they are just not. There's half of them wouldn't live with each other if they had the choice, but what choice do they have? So I strongly disagree with some of that. They group them together because so and so has got a wheelchair. Just because he's got a bloody wheelchair doesn't mean to say that they are compatible. And you could go on forever couldn't you. Steam comes out of my ears some times. And then we have got a challenging behavior group here. It's not a challenging behavior group - one sets off the other one. I know a couple of them that if they were put with the other ones who were quieter, as long as they are not going to be knocked around or whatever. As long as they are going to be protected. Safe. They shouldn't be grouped together as a challenging behavior group. We get one that screams the place down and then the other one gets angry because that one is making a noise, and then they all start.
> (H. Ward 1, Staff Nurse 2)

She identified the process of streaming and the formation of specialised groups and wards as factors that have contributed to a sense of resentment, and the cause of some problematic behaviours. Referring to the residents that use wheelchairs she asserted that any similarities that people presume they shared because of their physical impairments were not grounds for assuming compatibility within the group. Similarly in her description of the challenging behavior group she attributes the causes of their behavior to lack of space, noise and the incompatibility of group members instead of seeing it as an intrinsic aspect of their learning disability. Her description would suggest that they were acting in response to environmental stimuli; revealing acquired rather than innate patterns of behavior.

A Staff Nurse that was working on a ward that had been categorized as a challenging behavior area believed that a lot of the problems she encountered had been created because residents "simply just don't get on with each other". Members of the group were "constantly fighting and annoying one another". She also admitted that some of the rivalry was stimulated by a need to receive individual attention. If behaviors resulting from a lack of close contact, or individual attention, were going to be reduced in the future then she thought it would be necessary to make the groups even smaller:

I think a maximum of three people really. Although they are very able they do require a great deal of individual attention. If they can't get the attention then they play each other off against each other and they use the staff to wind each other up. There are so many fights and arguments purely because of the fact that they don't get enough attention. I mean whether it's good attention or bad attention - that's what they want. If it means that somebody is going to go their room with them and giving them a bit of a telling off, or going down to their bedroom and doing something nice with them - its attention. So it doesn't matter what they do as long as they get that attention. So I think that's important. They do need one to one here, which unfortunately, we just can't offer at the moment.
(H. Ward 2, Staff Nurse 1)

From her perspective the ward had brought people with similar abilities together in an environment where they had to compete with one another to gain individual attention. She was convinced that the demands made on the staff, due to the size of the group and the urgency of their needs, made it difficult to offer one to one attention. To secure individual attention residents had learned to "play each other off against each other" and use the staff to "wind each other up". To reduce, or eliminate the impact of competition the size of the groups would have to be reduced but she believed that the ratio of staff to service users had to improve before they were in a position to offer "one to one" care.

During the interviews people identified a variety of factors that were influential in assisting or impeding an individual's progress in the community. Some of the factors were personal attributes of the residents they had been working with. These included references to personality, appearance, communication or behaviour. When interviewees described the transferal of services between hospital and the community they described how some individuals were going to find the transfer easier than others. Interviewees used personal attributes to explain why some residents were going to find the process of adjusting to a different environment difficult, or to describe how some of the behaviour that was exhibited in hospital would evoke a strong, negative reaction from people in the community. Some of the interviewees that were working in the community were able to identify environmental factors that had made it difficult for the residents to derive the maximum benefit from their location. These factors included details of their physical surroundings as well as factors

pertaining to the availability of transport or day care packages. The final part of this section on streaming and classification contains material from the interviews that draws on all of these factors. Material from the interviews has been divided so that it is represented in two categories. The first category contains material that has focused on personal attributes. The second category contains material that has focused on physical and environmental factors.

Progress in the Community: Personal Attributes

Staff interviewed in the hospital suggested that the people who were going to benefit from the move into the community were the people that had received the most attention while they had been living in the hospital. They believed that staff were inclined to work with residents that responded positively to a change in their environment rather than residents that did not indicate that they were aware of change, or residents that were likely to respond in a manner that was deemed to be inappropriate or challenging. One interviewee stated:

> Obviously the people that are more able are going to benefit more. Because they are going to be able to use local facilities and all sorts of things. And I don't care what anyone says the staff are always much more willing to take out people who are more able than ones who aren't. We take them everywhere here. They are very good in this particular place. But there are not many people who want to take somebody who is severely disabled to a swimming pool or things like that, or someone who is very noisy. We have got a few that are very noisy here. I've taken them on holiday and they drove me round the bend because you just can not take them into a restaurant. They frighten all the children and things like that. That is very, very, hard. That doesn't mean to say that we don't want them to go out but how do you integrate them in a restaurant or something like that? And there's lots of staff that won't take them out for those reasons. They're not going to benefit.
> (H. Ward 1, Staff Nurse 2)

She thought that the people that would derive the greatest benefit from the move into the community were the ones that had already gained some experience of the public or local amenities. They were likely to be the residents that the staff, and members of the public, regarded as less threatening. She stated that some of the residents posed a threat to the public because their appearance, or behaviour, attracted attention in public places like a swimming pool. Similarly residents that made a lot of noise were perceived as a threat.

Her description suggests that staff avoid threatening situations, and confrontations with members of the public, by selecting the more able residents for trips and activities outside the hospital, and leaving the less able residents on the ward.

One of the interviewees said that she believed that people with physical disabilities or profound learning disabilities received different treatment. Describing a group of residents that she was working with she stated:

> Like I said before, the majority of the ones that we have got here, they are not going to be that much advantaged. All it is to them is that they are going to be put somewhere else and given the same sort of things that they have got everyday here. Which isn't a lot because they don't understand the things. They don't understand if they are going out. Therefore you don't take them out any less, but you think to yourself, well I'm not getting through to them so what is the point. You still keep on trying. If you take someone out who is a little bit more aware, and you can actually see on their face that they enjoy it, you would be more inclined to take them out again rather than somebody else.
> (H. Ward 1, Care Assistant 3)

She believed that the quality of the resident's lives was influenced by a combination of factors. The interviewee has stated that some of the residents showed that they enjoyed going out by the looks on their faces. They were regarded as people that were capable of appreciating a change in their environment. Other people reacted in a way that was difficult to interpret as a sign of enjoyment or displeasure. On some occasions people that had not been able to convey clear messages about their feelings were seen as being incapable of understanding what was happening to them, or unable to appreciate the benefits of change. Their capacity to respond to different situations was a factor in the relationship that developed between staff and residents, and therefore a factor in the selection of people that were taken out regularly. The interviewee believed that staff were more likely to take residents out of the hospital, and introduce them to new situations, if they showed that they were aware of what was going on. Another interviewee that was working in the community expressed similar thoughts when she stated "The people who

speak are more likely to be get heard" (C. Home 1, Assistant Home Manager 1).

In the documentaries about Stoke Park the residents that were presented as the beneficiaries of community care were people that were capable of conveying their own opinions on the subject. Ernie Hadfield was able to tell the interviewer his reasons for wanting to move away from the hospital. He expressed his views on the advantages of living in a hostel, and the disadvantages of living on a large ward. The hostel was near to his sister in Harrogate, but he also saw it as a part of the town:

> You can go out down the road, up there, and there's a railway station down the bottom of the main road, and you can spend your money in some of the shops down the road as well. I liked that place very much I did.
> (Update: Situation Subnormal?, 1983)

Although these amenities were available in Bristol, the location of Stoke Park and Mr. Hadfield's lack of contact with people outside the hospital, made him feel isolated. He saw the hostel as better place to live because it had provided him with more opportunities to participate in day to day activities in the community. His views on the conditions that he would prefer to leave behind were succinct:

> I don't like being here with all these boys because they gets on your nerves. They upsets you here and you can't sit down and have your meals in peace and quiet here. You get quarrels, shouting and bawling at one another. You get that from one meal to another, from breakfast time to dinnertime, and dinnertime. I don't like arguing with people like that. I don't take any notice of it. I just get on with my own way.
> (Update: Situation Subnormal?, 1983)

Mr. Hadfield had made a clear distinction between his preference for "peace and quiet", "his own way", and the behavior of the other residents on the ward. Christopher Sheppard expressed similar views in 1996 during the documentary on the closure of Stoke Park. Mr. Sheppard was living in one of the larger homes managed by the Phoenix N.H.S.Trust:

> I want to go to a smaller house. I think that would be better for me really. A bigger house is not very good because for me because some people like shouting, and swear, and it gets on your nerves. There's no peace here really. And now I have got more of a future, now, out of hospital. I can do more now. I can go down town on my own
> (Close Up West, 1997)

Although he had moved away from the hospital he felt that the conditions in the house were similar to conditions that have been described by Mr. Hadfield. He has also made a clear distinction between his own preference for "peace" and the behavior of other residents that like to shout and swear. In both instances the residents were able to express their feelings and wishes in a manner that distinguished their needs from the other people they lived with.

When interviewees discussed factors that were likely to assist or impede an individual's progress in the community they indicated that responsiveness to new people or situations, and the ability to express thoughts and feelings, were attributes that would enable a person to make rapid progress. Interviewees were convinced that any tendency towards violent or disruptive behavior would become a barrier to progress.

Care Assistant 2 believed that her views were representative of the views of many people in the community. She acknowledged that many of the residents should "go out" but she stated that she would not like to have some of them as neighbours:

> Certain people just don't want them around do they? I mean, don't get me wrong, but I wouldn't like them living near my home. Not with my children. Some of them can be quite violent. You don't know. Many a time the residents have struck people. You know. Things like that. Here it's not unusual. I know they are enclosed and all this, and they should be going out, but some of them haven't got the ability.
> (H. Ward 1, Care Assistant 2)

If there was a possibility that a resident might behave violently she thought that it was justifiable to use enclosure as a way of protecting the public. From her perspective a person's presence in the community was not a right. It was

subject to their ability to exercise a degree of self-control. Care Assistant 1 shared similar views about relationships with neighbours:

> Obviously its very difficult with people with challenging behavior to house people in the community - where you have got John and Jane next door and their 3 year old boy. And straight away you couldn't. With people with challenging behavior you could be looking at plots of land where the amenities are close by and the building isn't ugly and grey. The brickwork isn't going to be a nice building. And its not out of the way - it's in the community. It's bordering on a community setting. Because I don't think there are two ways about it. Challenging behavior - you can't have somebody next door to you who is throwing furniture and smashing windows and everything. It's not really acceptable I don't think.
> (C. Home 1, Care Assistant 1)

Like the previous interviewee he thought that integrating people with challenging behaviors into the community would be difficult. He believed the barriers that prevented the formation of more positive relationships were caused by the threat of damage to people and property. He envisaged that the solution to the problems posed by the relocation of the services could be resolved by building on land that was close to local amenities, but detached from them. Although he did not mention "enclosing" the land he seemed to think that some measures that offered the public degree of protection were justifiable. Both interviews thought that people who exhibited violent or destructive behaviour required accommodation that excluded the use of ordinary housing or sites that were likely to expose the public or private property to an unacceptable level of risk. Their views are indicative of the predicament described by Malin et al. (1999, p.49) who has stated that the provision of care in the community has created more risk. Although the move away from institutions has been associated by a desire to grant individuals more autonomy and freedom from the constraints of excessive control and over-protection, autonomy itself has created a succession of challenges for health and social services. For people with a history of severe mental illness, psychotic or anti-social behaviour this has led to community care "being queried as a risk worth taking".

Progress in the Community: Physical and Environmental Factors

Many of the interviewees perceived physical impairments as a barrier to integration. During the 1983 documentary Yvonne Wiley (Consultant Psychiatrist, Stoke Park) had defended the maintenance of hospital services, alongside community development, because the hospitals provided resources for people that required intensive treatment or constant supervision:

> About 30% of our residents in this hospital are bad epileptics and need quite intensive medical treatment. We also have about 10% of people who are mentally handicapped have serious, superimposed psychiatric illness and do need quite a lot of psychiatric treatment and medication. So it is a bit of an oversimplification to say that none of them need to be in hospital. Clearly some do. Many don't. What we would really like to see would be to have enough appropriate accommodation and provision for everybody.
> (Update: Situation Subnormal?, 1983)

In her view residents with severe epilepsy or a serious psychiatric illness needed to be cared for in a hospital environment. During the interviews that were conducted in 1996 some of the interviewees expressed similar views. Care Assistant 1 described a woman she knew with epilepsy. The Social Worker in the hospital was trying to find a flat for her:

> It's all right saying "She can do this and she can do that" but then you have to think she's an epileptic, she doesn't like being on her own and things like that. I don't think there's a lot of thought put into putting people out into the community. I don't think there is.
> (H. Ward 2, Care Assistant 1)

Although the resident she was describing had acquired self help skills the interviewee was not convinced that the Social Worker had made a prudent decision. The woman had developed skills that made her more independent but her epilepsy was perceived as a barrier that prevented her from living on her own. In hospital the resident had been surrounded by people that were able to provide assistance in an emergency. The interviewee believed that if the resident moved into a flat she would not be able to rely on her flatmates, or neighbours, to the same extent.

Even though epilepsy had been identified as one of the factors that was likely to make it harder for a resident to move away some of the interviewees

recognized that epilepsy and other physical impairments constituted a barrier in the hospital environment as well:

> I think years ago you found, especially with things like OT, it was always the same ones who were going out all the time. The OT would take the same ones. The ones that they were afraid, like Old Fred might dirty himself while he was out, Old Fred might never get a look in you see. So he wasn't really getting anything out of that because he wasn't allowed to go out and share the same in the activities of the others because he might dirty himself. I think you will still find that. I know you shouldn't actually find it. I suppose it still does go on. Certain residents aren't allowed out because they are afraid they are going to have a fit when they are out, or they are going to soil themselves, or cause a ruckus wandering around. They should still be allowed to do that because we are trained to deal with the situation if it happens.
> (H. Ward 3, Staff Nurse 1)

People with epilepsy, incontinence, or challenging behaviors were regarded as a sub-group in the hospital population. Because some of the staff were wary of taking them out they were often left on the ward. This had led to them being omitted from a range of social activities. The presence or absence of physical impairments, combined with the staff's impressions of an individual's communication skills, temperament and personality, were factors that exerted a powerful influence on any decision that determined whether a resident would be included or excluded from an activity. This combination of factors also determined which individuals would gain experiences that familiarised them with people and places outside the hospital and which individuals were confined in the hospital environment. Staff saw people with physical impairments as the recipients of more intensive nursing care. Their physical care was a priority rather than the social or psychological aspects of care. Care for these individuals was often characterised by an emphasis on the ability of the staff to manage incontinence, epilepsy or immobility rather than creating opportunities for the resident to engage with recreational and occupational activities.

Staff working in community homes believed that it was difficult to secure day care packages for people with profound or multiple disabilities. The problems they experienced securing recreational and occupational places were attributed

to the level of supervision that was required during activities and the problems that the staff associated with transportation. When individuals were able to make use of public transport, communicate their intentions, and handle money, they were likely to secure day services. Individuals that were unable to demonstrate these skills, or residents with physical impairments that required assistance with dressing and undressing, or the use of toilet facilities, were less likely to secure day care packages. While some of the residents in homes were able to benefit from the services that were available in the community other residents with multiple impairments were becoming house bound. Unlike residents on a ward they did not have any opportunity to make use of the facilities that were available in hospital.

Home Manager 1 described two scenarios that reflected his experience of services in the community:

> What I found is things like RAC places are in notoriously short supply, and anywhere where there is a high degree of staffing and supervision required. You don't have that level of input then so its difficult. If you're someone that can manage your money, get there on a bus, not be incontinent, need very little supervision when you get there - then you are going to get a good day care package out of it. But if you are someone that's in a wheelchair, got communication problems, limited finance, need transport to and from the place, need a fair amount of supervision while you are there. If you are incontinent as well. You are going to have a hard time getting a good day care package unless somebody is going to address all of those issues for you. A lot of service provision for day care, or day services, or activities in the community isn't geared up for those sort of people. It's geared up for the others. The ones that tend to have very good packages are those people that can do things. We go out of our way to transport people all over the shop because we're not in anybody's catchment area, so nobody ever comes here and picks up, apart from one place, comes and picks up the residents, takes them and brings them back for us - doesn't need any supervision. By and large all the college courses, we take them to, stay with them and bring them back. It provides quite a drain on all the resources in the house.
> (C. Home 1, Home Manager 1)

Residents that required assistance with mobility were experiencing additional problems because of their surroundings. People that were not able to obtain day care had to find activities around the house, or in the local area. For people

in wheelchairs any activity that involved going outside of the house presented a series of challenges. Residents that required another person to push them, or people with visual impairments that required someone to guide them, needed a member of staff to accompany them. Leaving the house to visit the shops or a cafe was only feasible when the ratio of staff to residents permitted it.

Interviewees stated that because of the number of people living together, and the allocation of staff during a typical shift, it was difficult to achieve a balance between the needs of the individual and the needs of the group that remained behind. If a member of staff went out with one resident it imposed restrictions on the type of activities undertaken by the residents and staff that were left behind. Some of the staff working in central Bristol found that they were using cars to travel short distances because it was too difficult to maneuver wheelchairs around the roads and pavements in their vicinity:

> Clifton is a very beautiful place to be. But with wheelchair access it's not easy. It's very difficult to get people out but you can do it anyway, you just take them in the car to get somewhere, wherever, and then walk. Particularly with wheelchairs it's more difficult.
> (C. Home 1, Assistant Home Manager 1)

Even the residents that were mobile had some restrictions imposed on them. Home Manager 1 described Clifton as "notoriously unsafe". The combination of cobbled streets, high pavements and frequent steps made it difficult for some of the elderly people to walk unaided. Before any of the residents were able to go out on their own the staff had to conduct a risk assessment to determine whether or not they could leave the house without someone to supervise them.

Conclusion

This chapter has examined developments at Stoke Park between 1960 and 1997. Analysis of data from newspaper reports and documentaries has shown that during the 1960s and 1970s conditions in the hospital were described as squalid and "Dickensian". Interviews with nursing staff recorded in 1972 contained accounts of overcrowding and privation. The accounts of poor conditions at Stoke Park were consistent with other accounts of dilapidation

and overcrowding at Ely Hospital (1967), Farleigh (1971), and South Ockenden (1974). In the late 1970s and early 80s the South Western Region Hospital Board implemented a programme of refurbishment and rebuilding to improve living conditions in the hospital. Improvements included upgrading the older wards, demolishing some of the large, dilapidated buildings, and constructing smaller units. Although "Better Services for the Mentally Handicapped" (DHSS, 1971) had reinforced the principle of developing community based services the level of investment in new buildings on the hospital site, and the shortage of alternative accommodation in the community, meant that Stoke Park was still regarded as the hub of learning disability services.

The hospital closed in 1997. Data collected from interviews in 1996 has shown that nursing staff saw closure of the remaining wards at Stoke Park as the final stage in a lengthy process that had entailed the systematic reduction of the hospital population. Some of interviewees were able to use the closure of the hospital as an opportunity to compare and contrast the group of residents that were waiting to move out with former residents that had already moved into the community. Analysis of data from the interviews has shown that the group that remained in the hospital were similar to the "back ward" population described by Jones (1975, p.96). The group remaining at Stoke Park had developed around a nucleus of people with learning disabilities that was perceived as highly dependent. They included very elderly residents, people with physical impairments and mental health problems in addition to learning disabilities, and people with challenging behaviours. Interviewees believed that residents on the remaining wards required intensive nursing care and support. They mentioned the management of epilepsy, incontinence, aggressive behaviour, self-harming behaviour, and destructive behaviour, as areas that required specialised intervention.

Interviewees contrasted the support they were providing for the residents that remained with the support that they had given to the residents that had already moved out. The first groups to move into the community had consisted of residents that were described as "more able". They had required less intensive nursing care and support in the hospital environment. Nevertheless

interviewees claimed that the hospital staff had assisted with their transition from hospital to the community by teaching the residents skills that would enable them to function more independently once they were established in the community. The contrast between the "more able" group and the group that had remained in hospital was expressed in the interviewees' descriptions of the challenges that they would face in the future. They predicted that the "less able" group would not be able to benefit from the move in the same way that the "more able" group had. This was attributed to a combination of factors that reflected the severity of their intellectual and physical impairments, and the level of support that they would require to participate in everyday activities in the community. The integration of people with challenging behaviours was seen as particularly difficult. Interviewees believed that the level of risk associated with violent and destructive behaviour meant that access to facilities in the community would be restricted.

Data from interviews with staff working in community homes provided evidence that corroborated the views expressed by hospital staff. They stated that environmental factors e.g. busy roads, wheelchair access, made it difficult for residents with physical and sensory impairments to participate in activities in the local community. They believed that the "more able" residents in community homes had benefited from the move. These residents had access to a range of experiences that were not available to them in a hospital environment. There was also evidence indicating that the "less able" residents did not share the same range of experiences. Although some aspects of their lives had improved e.g. more personal and private space, better décor and food, residents with poor communication, mobility and continence problems were finding it difficult to obtain day care packages that enabled them to participate in recreational and occupational activities.

Chapter 7 will continue to examine the micropolitics of developments at Stoke Park Hospital. Data has been derived from interviews with nursing staff and documentary evidence. Analysis of the material will explore how the plan to close the hospital and expand provision in the community, has effected the role and function of services and the allocation or resources and responsibilities.

Chapter 7

Stoke Park 1960 - 1997

The Role and Function of Services

The first part of this chapter will look at the views of qualified and unqualified staff on the role and function of services for people with learning disabilities. Material from the interviews has focused on the ways in which the closure of the hospital, and the movement between hospital and the community, have influenced staffs' perception of the services and the roles they perform within them. The first part of this section contains material that conveys the interviewee's perceptions of the duties and responsibilities of Registered Nurses and Care Assistants. The material also includes comments that record the staff's perception of the impact of change on people and the services. The second part of this section contains material that is focused on the changing role of the hospital and interviewees perceptions of the services that have been established in the community.

Registered Nurses and Care Assistants

Both qualified and unqualified members of staff commented on the amount of time that was spent performing administrative tasks. One of the qualified nurses that was interviewed thought that the amount of time she spent on paperwork encroached on the time that she could spend with residents:

> As a qualified staff you're expected more and more to be doing paperwork and so obviously you've got less time to spend with the residents which is what you're really here for.
> (H. Ward 1, Staff Nurse 3)

Although the interviewee was working on a ward where the infrastructure of the hospital provided some support with administration, as well as cooking and cleaning services, she found the volume of paperwork that she was required to process had reduced the amount of time that was available to maintain relationships with the service users. She believed that the number of administrative tasks that demanded her attention compromised her ability to

deliver the sort of care that she was "really there for". One of the Care Assistants, working on the same ward, thought that the qualified and unqualified staff did the same job but the qualified staff had the added "responsibility" of administration:

> They have got to answer phones, and fill out forms and see to things like that.
> (H. Ward 1, Care Assistant 2)

Her views on the impact of office and paper work were similar to the previous interviewee. She believed that the unqualified staff had a greater impact on the quality of the residents' lives because they were able to "get more time to be with them" and become "closer". She described the activities of the qualified staff as a series of responses to administrative tasks rather than developing relationships with the residents:

> Poor qualified don't get a chance really to sit down because something has to be done. Some form has to be filled out, or drugs, or things like that. There's a lot of responsibility goes with running a ward. Personally I would never go to being a qualified. I enjoy being an N.A. Quite a lot of the girls on here would say the same thing.
> (H. Ward 1, Care Assistant 2)

The same interviewee thought that the number of staff available for each shift was not sufficient to expedite the delivery individualised care. She did not think that there was a lot of time available for her to divide between the completion of routine tasks and paying attention to the needs of each resident. Although they had the ability to do more for themselves the staff could not provide the one to one support needed to cultivate skills that would make the residents more independent:

> To be honest these sort of clients that I work with now really need one to one. If they had one to one all the time it would bring them on so much. We really would. Every little thing would happen theirselves. But when there's only two of you or sometimes one if one's late, and eight residents, sometimes it's impossible. Really impossible sometimes. There's so much going on in the ward anyway. Its little things like laundry, and bags to be changed, and beds to be made. Do you know what I mean? If you had more staff you could all get on and do it. It would make life a lot easier for

> them. They don't get as much quality time as they should really to be honest.
> (H. Ward 1, Care Assistant 2)

On the wards there was tension between the amount of time that was devoted to domestic tasks e.g. dealing with the laundry and making beds, and the availability of "quality time" that could be shared with the residents. Although the staff believed many of the clients would benefit from the interactions that they associated with individual attention, or small group sessions, they perceived the accumulation of domestic duties as a barrier to developing their activities in this area. The importance that has been attached to "one to one" methods of working may be indicative of the clients' needs but it also shows that teaching and training were perceived as intensive activities that excluded other tasks and the facilitation of large groups. To create "quality time", and foster the appropriate environment for teaching and training, the ratio of staff to residents would have to improve so that there was sufficient people to maintain basic domestic services in addition to facilitating learning. In the interviews with qualified and unqualified members of staff interviewees expressed the belief that all the staff were on the ward for the benefit of the residents but their ability to sustain satisfying relationships, or "bring people on", was curtailed by the other tasks that they had to perform.

One of the Registered Nurses interviewed was a Home Manager in a large community home. He described his work as an amalgamation of managerial and nursing skills. During the interview he stated that the job of qualified staff in a community home was becoming "bureaucratic" and "complicated". He believed that the quantity of paperwork had risen to a level that would deter some qualified staff from working in the community:

> You've seen this morning how this job can get to the point where you think there's so much bureaucracy involved in our job these days and so much paperwork. They have made it so much more complicated than it ever used to be. I can understand people that - if they don't realize that's what they're letting themselves in for - going off the idea very quickly.
> (C. Home 1, Home Manager 1)

He believed that the responsibilities of a qualified nurse working in the community, combined with the emphasis that the service providers had placed on accountability, made the job more demanding than a comparable post in the hospital:

> The responsibilities that I had as a G grade in a ward - running a ward of twelve to fourteen people with challenging behavior - and the responsibilities that I've got out here with just eight extra people, who have got less needs, well, its just more than half. It's quadruple the amount of responsibility. You really do feel that you are accountable, whereas in the hospital you tend to be a little bit more protected. If something went really bad there's the hospital manager; there's the care manager. The accountability here is very much bigger. I can see people who have been about for a long time thinking "Why bother putting myself through that'.
> (C. Home 1, Home Manager 1)

When qualified nurses were working outside of the administrative and managerial structures provided by the hospital responsibility for administration and record keeping was devolved to Home Managers or Team Leaders. Some of the qualified nurses that were interviewed saw their role as managers rather than "hands on" nurses. This interviewee thought that the closure of the hospital would be a watershed for some of the staff that had held positions as Ward Sisters and Charge Nurses for a long time. Rather than accepting more responsibility he believed that they would prefer to "sign on the dotted line" and take early retirement. Some of the qualified staff working in the hospital agreed with his views on accountability and responsibility. One stated that she thought her work would be a lot harder when she moved into the community:

> People that are already out there are saying that it's a lot harder out in the community. I don't mean harder as in physical work. You've got to be a lot more aware. Whereas now we just trot over to a doctor, whereas then, you know, you've got to think about things. Do they really need to go to a doctor? There's more responsibility, I think, on you. You've actually got to think of them, I suppose, as you would your own family, your own children or whatever.
> (H. Ward 1, Staff Nurse 3)

She envisaged that her work will be harder in the future because of the type of decisions that qualified staff are expected to make. From her perspective responsibility and accountability were becoming more prominent aspects of

her role because of the process of decision making that they entailed, as well as the paperwork and recording they produced.

Although many of the qualified staff thought that paperwork and administration occupied more time than they had done in the past they were regarded as tasks that had been added to their previous role. Most of the qualified staff recognised that their positions entailed a level of managerial responsibility but they had not relinquished their caring role. Within the working environment they had to make decisions about the importance of different tasks and the allocation of their time. Decision-making often created conflict between the need to provide solutions for exigent problems and the need to develop longer-term strategies. The management of staff on the ward, or in a home, was often cited as an area that precipitated conflict of this nature. Qualified staff had overall responsibility for monitoring the quality of care that service users received. When they had been involved in the delivery of care they had been able to use their day-to-day contact with the staff and residents to talk about developments and suggest improvements. As their managerial responsibilities had increased they spent less time with the clients, and staff so that the time available for informal discussions, and the opportunities to present themselves as role models, had decreased. At the same time the reduction in the services that were available on the hospital site, and the isolation of staff in community homes, meant that some qualified staff felt that it was incumbent on them to provide guidance for the rest of the team. Some interviewees talked about supervision and providing training for the unqualified staff as a part of their managerial role, and a way of improving the quality of care. In some of the other interviews the interviewee acknowledged that there was a need to provide support and staff training, but they were less willing to recognize it as a part of their job.

Staff Nurse 2 described the potential for conflict between a disciplinarian orientation and a more educational orientation:

> I mean its up to us to try and get it through but again its like I said you've not got enough staff to spend time teaching other people things. All you can do is, like I said in one of the questions there,

> mostly when you are qualified its managerial. You spend all the morning in the office; you may not see a service user or resident during that morning. You're too busy doing other things, so how the hell do we teach the unqualified? All we can do is come on and catch them doing something and say we don't do it that way we do it. And this is what we tend to do. I mean obviously we have got policies on the wards or in the files.
> (H. Ward 1, Staff Nurse 2)

In the scenario that she has described there is conflict between the tactics that were required to deal with an inappropriate response to a situation, and the tactics that would encourage a member of staff to think and respond in a different way. The response that she had described has separated opportunism, management of the problem and its immediate consequences from a commitment to staff training. She has cited the pressure of office work as an obstacle that has restricted her teaching activities to catching people "doing something" instead of spending more time assisting the person to approach the situation differently.

The same Staff Nurse also stated that she believed that changing the attitudes of the staff was a step towards improving the service users' quality of life. She thought that her comment was especially pertinent regarding the attitudes of unqualified staff:

> I think there needs to be a lot of attitudes changed. Maybe not so much the qualified, although there are qualified as well, but more so the unqualified staff. Because I've heard some of the attitudes. You hear a lot of things in here. I mean I've worked in a community home, briefly, as well but its no better. In fact when you're in a community home, once you get behind the door then you hear people saying doing the ironing, washing, and cooking and everything else. The people that live in the house come last really. It's not going to be any better.
> (H. Ward 1, Staff Nurse 2)

She believed that attitudes had at least as much bearing as the environment on an individual's behavior. The attitudes she has described made it appear that staff preferred to occupy their time performing domestic tasks instead of engaging with the residents. The experience she had gained from working for a brief period in a community home had convinced her that this sort of behavior was not confined to staff working on hospital wards. Some of the

other interviewees claimed that there were attitudinal differences, and working practices, that had been engendered by the "old regime" at Stoke Park. These differences were as distinctive as the differences between qualified and unqualified staff:

> The old timers may not relish something new. They are so used to the old system. As you will get staff coming in from outside that didn't know the old regime, obviously it will be easy to teach a new person new tricks for us, but totally alien to them, because they are not used to that sort of thing. But for an older member of staff I would think study days to get them to get them into that way of thinking. With the residents that are here, there but for the grace of God go I, if they want to invite a friend into their room to have a cup of tea or something they should be allowed to do that. If they want to go off and have a coffee in a coffee bar - they should be allowed to do it. Not you can't do it unless somebody goes with you sort of thing.
> (H. Ward 3, Staff Nurse 1)

The staff that had been working in the hospital for a long time were seen as a source of resistance to new ideas. Their attitude towards the residents on the ward combined reliance on disciplinary measures with a tendency towards protectionism. When they had been confronted with resistance of this nature the residents found it difficult to exercise their independence. On the wards where these attitudes prevailed a resident would be expected to request a member of staff's approval before going out for a cup of coffee, or taking a friend into their room. In the scenario the interviewee has described it would appear that on some occasions approval had only been granted when the resident agreed to additional conditions involving supervision. The interviewee had not indicated that he accepted any responsibility for confronting or changing these attitudes. He believed that "study days" would precipitate change.

The Staff Nurse from "Home 2" believed that the redeployment of staff had created conflict in the home where she worked. Differences in attitudes and working practices had escalated to a level where members of staff were no longer able to work together as a team. Although some of the members of the team had recognized the problem training had become a contentious issue

because of the amount of time that had been dedicated to improving the team's performance:

> Because Stoke Park is closing we have been actually forced to take staff from Stoke Park who really aren't up to functioning at the level they need to function for this type of area that want to move on. We are now spending more time with those members of staff, actually teaching them the principle of community care, I suppose, than spending time with the service users. So the staff team is basically holding back "Home 2". At the moment that is what I say anyway, but mainly because we have been forced to take on members of staff that we wouldn't have employed within the service, but we have been forced to do that.
> (C. Home 2, Staff Nurse 1)

The interviewee believed that the amount of teaching that was required to encourage some of the most recent members of the team to function at an appropriate level had prevented the rest of the team from working with the residents. She stated that the attitudes of some of the staff, and the levels of support and supervision that they needed, had led to a decline in the standard of care that was being delivered. From her perspective the staff team was holding the residents from "Home 2" back.

Teams that had started to address issues around staff supervision and training found that it demanded a lot of their time and attention. The compatibility, or incompatibility, of staff joining established teams in different areas was an issue that had been accentuated by the closure of wards at Purdown and Stoke Park and the subsequent movement of staff around the Trust. Although qualified staff had responsibility for managing the teams on a ward, or in a group home, they were not in control of the movement of staff from one ward to another, or one home to another. In "Home 2", and some of the other wards and community homes, conflict had been created when staff had been moved into an environment where their attitudes and working practices were not compatible with the existing team. Supervision and training were strategies that the established staff had implemented to diffuse the conflict that had ensued.

The Residents' Experience

The Home Manager from "Home 1" had worked at Stoke Park and then moved away to manage a home in Bristol. When he discussed residents that had made a similar move from hospital into the community he acknowledged that although there had been improvements in their quality of life, some people were not able to find enjoyment in the activities and relationships that had occupied them in the past. Residents that had worked in the hospital, and residents that had been able to move around the site had been able to get to know people. They had established a reputation and status within the hospital:

> I can think of one resident in particular, well regarded in the hospital environment. Been there years, got the respect of the other residents. He did things. He would walk around the hospital grounds and people would say there goes so and so - good bloke. Come out here and nobody knows him. The other residents know of him but they didn't live on the same ward as him. They aren't as able as he is so they don't have that sort of ... he hasn't got his peer group. They're left behind. Although he wanted to come and he says he enjoys living out here. But you can see he is very much more isolated here than he would be in the hospital environment. And he hasn't got the freedom of access.
> (C. Home 1, Home Manager 1)

Residents had moved away from an environment where they were well known to live in a busy area of Bristol where they were anonymous. They were experiencing some disorientation. When the Home Manager described his neighbours he said that they were not hostile or unfriendly, but they tended to "look you up and down" or "just walk past you". In the hospital the resident that he described had felt some connection with the people around him. In the community he was isolated. This was accompanied by a sense of confinement:

> It's better but the fundamental thing that is missing is that he hasn't got that sense of camaraderie that he had in a place like Brentry. He hasn't got that freedom of access. Since he's been here I've said to him that he "You can't go wandering about on you own".
> (C. Home 1, Manager 1)

In the hospital the residents had been able to visit the other wards and walk around the grounds. Although they were cut off from the rest of the

community they enjoyed the sense of security and freedom of movement that they had on site. Once the residents left the hospital they were considered to be at risk in an unfamiliar environment.

Care Assistant 2 had moved from Stoke Park to the same community home. He stated:

> Here they are not allowed to go anywhere. Here they've got, it's not even an acre, and they have to run around in that, and that's it, because they're not allowed outside the gates. In all of the other hospitals they had about fifteen acres to run about in and they had the freedom, now most of them are bored. They haven't got the money to get them out. It's all down to whether or not they smoke. They couldn't afford to smoke twenty cigarettes a day if they wanted to. So like everyone goes on about they've got choice, but they have a very limited choice.
> (C. Home 1, Care Assistant 2)

For some of the residents the move into the community had made them subject to restrictions that had not been imposed in hospital. Residents that had enjoyed the space to move around, and the freedom of movement, had fewer opportunities to exercise their independence. In a busy urban environment some of the residents were confined to their houses and the use of a garden. In addition to the restrictions that had been placed on their movement people living in the community were also noticing the impact of poverty. When the cost of food and accommodation had been deducted from their benefits they were not left with a lot of money to pursue activities outside the home. While they were in hospital the residents had been able to benefit from economies of scale that enabled them to purchase items such as food, cleaning materials and toiletries comparatively cheaply. In the community these items were more expensive, and the residents had to pay for transportation as well as the retail price of each item. This had diminished the amount of money that was available to spend on recreational activities. The cost of going out, rather than using facilities and entertainment provided in hospital, meant that the cost of each activity was a major consideration.

Although the movement into the community had been accompanied by a sense of loss for some aspects of hospital life, most of the interviewees

thought that the residents had gained something from the move. Home Manager 1 had spoken about the things that one of the residents missed when he moved away. During the interview he also made a list of the things that the resident had gained when he moved into the home:

> If you look at some conditions like he was living in a prefabricated ward, and now he's living in a nice posh flat. He was living with fifteen or sixteen other people and now he's living with just five other guys. He was having perhaps one, maybe two staff on duty to look after all fifteen now he's got two staff on duty just to look after only six of them. You would think, yes, he's got more choices than he ever had before. He's got a better range of many facilities. You know he's eating food now that he never had before in his life. He's going to places that he's never had access to. He was going to the OT Department now he's going to the South Bristol College. He's going out to Filton to the Leisure Center. He goes out to the local churches. People take him. The Day Care Workers take him. It's all according to what you like.
> (C. Home 1, Home Manager 1)

Residence in the community had provided some people with opportunities and choices they had never experienced in hospital. People that had moved out of old buildings or prefabricated wards had a "posh flat" in their new home. The appearance of the rooms they lived in, the furniture that they used, and the food they were eating had improved. For those residents with access to the appropriate resources there was also the chance to enjoy a variety of courses and recreational activities.

Hospitals to Community Based Care

The final part of this section will examine the changing role of the hospital and the interviewees' perceptions of services in the community. The material includes interviews and documentary evidence that describe the range of activities that have taken place at Stoke Park. In an article that appeared in Bristol's Evening Post (1972) Dr. Heaton-Ward stated that hospitals for the "subnormal" would be needed for many years to come. He envisaged that the hospital would become a part of the community services so that people would cease to regard the hospital and the community as separate entities. During the article he said that it was a pity that the term "colony" had given way to the more prestigious term "hospital" with the inception of the National Health

Service. Heaton-Ward saw the colony developing into a village that would be recognized as an integral part of the community that surrounded it. People would welcome the "villagers" and vice versa:

> I would like to see a return to the colony concept at Stoke Park with its development as a village with all the facilities available to the residents in a normal village, including communication in both directions with other areas of the population.
> (Evening Post, 1972)

In addition he stated that the hospital would require extra resources to provide specialised care for the people that were being admitted with severe mental and physical impairments:

> The increasing severity of the mental and physical handicap of patients now being admitted to Stoke Park demands more rather than less skilled medical and nursing care and the specialist skills of physiotherapists, occupational therapists, dietitians, chiropodists and radiographers.
> (Evening Post, 1972)

His statement had been made in support of the recent developments on site. New wards had been constructed and redevelopment plans were in progress. In addition to the improvements that had been made to the accommodation he thought that the services on site should be expanded to meet the needs of a population that would require support from a variety of specialist practitioners. He envisaged that specialised services would be concentrated in a single purpose hospital environment. These views were not consistent with the aims of the ten-year Hospital Plan, or the views expressed in the 1971 White Paper "Better Services for the Mentally Handicapped"[1]. Both had suggested that resources should be directed towards the development of community care, and the use of general medical and social services, rather than hospital provision. Heaton-Ward's comments reveal the division between national policy and local provision. Although national plans endorsed the use of community services, in reality the services that were available could only provide limited support for people with severe mental and physical

[1] For more information on the 1962 Hospital Plan see Chapter 5, p.134 – 136, 149. For more information on the 1971 White Paper see Chapter 5, p. 151.

impairments. The needs of the people being admitted to Stoke Park indicated that they had to come into hospital in order to gain access to specialised practitioners and resources.

The accounts provided by interviewees did not accord with Heaton-Ward's vision of a village within the local community. Interviewees acknowledged that the residents had more contact with the community outside of the hospital, but improvements in communication were attributed to the staff and residents, rather than a change in the public's attitude towards people with a learning disability. Getting away from the hospital was seen as a goal that had precipitated many different social and recreational activities. Staff Nurse 3 believed that some of the staff that she had worked with regarded "going out" as an activity that was as valuable as "one on one" work:

> I call it "minibusitis". Sometimes you find that the staff, they love to get them out on the minibus but what they take them out for I really don't know as such, other than having a drive around. Sometimes that time could be better used on a one to one, doing something as an individual person.
> (H. Ward 1, Staff Nurse 3)

Some of the staff had interpreted incentives that encouraged more "community presence", and improved communication, as an inducement to visit the community. This had become an end in itself, rather than a way of enhancing participation in local events. The context in which the interviewee made this statement had a bearing on her answer. The interview had been conducted while she was working with a group of people with profound and multiple learning disabilities. Her response indicated that it was difficult to find activities that would engage them in the community. This had led her to believe that the residents would find "one to one" attention within the hospital environment as stimulating as being driven around in the minibus.

Care Assistant 1 worked with the same group of people. She thought that contact with people outside the hospital had improved their quality of life:

> Because I say they weren't able to go on holidays; now they can pay for themselves and the staff to go on holidays, to do their own

> shopping ... At one time they used to get the clothes from the hospital, which everybody would have the same thing. Nowadays they are in fashion because, I mean, each resident have their own key workers and then you can go out and buy nice things - like what you would for yourself, or your children - for them, you see, so it's better times now than what it used to be.
> (H. Ward 1, Care Assistant 1)

In the past residents at Stoke Park had been issued with hospital clothing. At the time of the interviews they were encouraged to use the shops in Bristol and purchase fashionable clothes. Staff had encouraged the residents to use the same facilities as other citizens. For some of the residents opportunities to establish contact with people outside of the hospital were limited to holidays and occasional shopping trips. Visitors taking an interest in the hospital had not reciprocated even this level of contact. The site remained detached from the local community. Any initiatives to promote integration had relied on residents and staff to instigate contact.

Interviewees believed that the hospital had been successful in providing a safe and secure environment. It provided an atmosphere that protected the residents from the hostility or teasing that some people had experienced when they moved into the community. As well as offering security it enabled residents to gain access to services without experiencing the tribulation of queuing or the frustration of being confronted with staff that could not understand them. Home Manager 1 described some of the problems that residents in community homes had experienced using General Practitioner services:

> We access all the community services just like everybody else. So when we go to the GPs we have to wait like everybody else does in the waiting room. You've got to remember that most of our residents came from a hospital-based service. When you take them to a GP's surgery, and they've got to wait for over an hour to see their doctor, they get a bit cheesed off with it - they have all sorts of problems. If they were at Brentry or Stoke Park, or wherever, the chances were doctor came to see them which, more often than not, never happens here unless there is a real emergency. GPs just offer a strict GP service. The first thing they say is can you bring them to the surgery. That side of things, accessing normal services is O.K. It's a normal existence, just like you or I would have, and that's the whole philosophy of the service these days. It does

present problems in that the service they had in hospital was geared up for more of their needs and they had access to it far quicker. Nowadays it tends not to be so good. A lot of them have problems with that, like standing in line for the doctors. Because they know they are going to be waiting in there for ages to see the doctor. Then it's in and out and they are gone. That's it. Prescription. Thank you very much! So they don't have that sort of rapport.
(C. Home 1, Home Manager 1)

Care Assistant 3 thought that the range of services available in the hospital had met most of the residents' needs:

> It's fine. I like the ways the wards are set out. It's good for them. The food I'm not so keen on. I wouldn't eat half the stuff they get let alone having to feed it to them. That's just my opinion. The other services that we have got on the site like doctors and dentists and all that lot, is very good. I mean that they have to go outside the ward to get to them, but they don't have to go too far so they know they are in a safe environment. And activities there are - the Burden Hall provides some, but then the rest of it is left to us and the OT staff. Unfortunately the OT staff has got to do the whole of the hospital so they are not able to take everybody out when they say they can.
> (H. Ward 1, Care Assistant 3)

Other interviewees identified different services that had been used by the residents on their wards. Staff Nurse 1 (H. Ward 1) mentioned the physiotherapists, speech therapist, and the provision of specialised items like footwear. Care Assistant 2 (H. Ward 1) mentioned that there was always somewhere for the people to go because the hospital had its own cafe, bar and disco. Although many of the respondents that were interviewed at Stoke Park wanted the hospital residents to experience life in the community they did not envisage that they would have access to the same range of services when the site was closed.

For many of the residents the advantages that they would gain from better accommodation were weighed against the loss of a safe and secure environment. June Townsend felt that moving into the community would result in the loss of her independence. The home that she was moving into was on a busy road. It was a modern building, with new furnishings, where she would

have a room of her own. The home offered the prospect of better accommodation and more privacy but Miss Townsend expressed some reservations about moving away from Stoke Park. The roads and pavements around the new home were not suitable for her electric wheelchair. Because the traffic in the hospital grounds traveled slowly, and the terrain and buildings had been modified to accommodate wheelchairs, she was able to move around the hospital grounds and attend activities on site without assistance from staff on the ward. The area surrounding her new home did offer the same level of safety and security. Miss Townsend thought that some of her freedom had been taken away:

> Up here I can go anywhere I like round the grounds. Up there I don't think I will be able to go very far when I go to that house. I might have to have somebody to come with me when I cross the road.
> (Close Up West, 1997)

While Miss Townsend thought that traffic and the state of the roads threatened her mobility, and her independence, staff working in the hospital predicted different scenarios that presented new threats. They believed that hospital was a safe and secure place because it had excluded or reduced the risks posed by individuals that would harm the residents. Although people that used wheelchairs were at risk from uneven road surfaces and fast moving traffic, residents that were able to go out without any supervision were still at risk from individuals that may expose them to verbal, emotional, physical and sexual abuse.

Hospital security, and the presence of the day and night staff, discouraged any individuals that might seek to harm the residents from coming on to the site. Staff believed that once these deterrents had been removed the likelihood of abuse was likely to increase. Staff Nurse 1 described one resident that was able to go out by himself in the hospital. Before he moved away the interviewee thought that he would need to be taught about the potential dangers posed by any individuals that might attempt to take advantage of him:

> Obviously it is harder with our residents because their degree of handicap is greater but I mean some of the younger ones that are

able. People like Graham that is able to go off and go out on his own. He knows his way around. He knows his road safety. But obviously years ago I suppose he was stopped, but he wouldn't have been allowed to. To give them they're independence, and obviously a safe element of freedom, because some of them could abuse it, and be abused by people outside. So it would also have to be for the brighter resident. Some kind of study day for them. Warn them against people who could harm them because they wouldn't know you see, would they?
(H. Ward 3, Staff Nurse 1)

Resources and Responsibilities

The final part of this chapter will examine the movement of resources between the hospital and the community. Material in this section has been derived from a combination of documentary evidence and interviews. The content of this section will show the incremental transition from a hospital-based service to community care over the thirty-year period between 1966 and 1996. Many of the responses demonstrated that the respondents were cognizant of policy operating at a national level but their experience of services at a local level had made them aware of the differences between the rhetoric and reality of community care. Some of the respondents suggested that the size and style of the homes that had opened in recent years made it difficult to deliver residential care that reflected the "ordinary life" principles espoused by service providers operating within the National Health Service and social care trusts. Although the principles of normalization, social role valorization and the service "accomplishments" identified by O'Brien (in Bellamy and Wilcox, 1987) had been incorporated into service philosophy (Frenchay Health Authority 1989), and the documentation for Individual Programme Plans (Phoenix N.H.S. Trust and Avon Social Services 1995) some of the buildings that were used to provide accommodation for people moving out of Stoke Park had not facilitated the creation of an ordinary domestic environment. The availability of resources, particularly the availability of funding that was designated for relocating residents from the hospital, had produced significant differences in the quality of residential provision that was available.

Dr. Heaton-Ward used an interview with a local paper to impart his concern about the lack of resources devoted to "mental handicap". Some of his concerns had been exacerbated by the differences between "mental handicap" services and other branches of medicine. During the interview he stated that there was a feeling shared between the public, and sections of the medical profession, "that money spent on the mentally handicapped is money wasted" (Bristol Evening Post 3/12/1966). He used subsequent interviews to expand his views. In 1968 he used another interview with the Evening Post to describe the strain that had been placed on the services because of a shortage of consultants (27/9/1968). He said that after four years of "pleading" an increase in consultant establishment it had not materialized. The following month he reiterated his plea in the Western Daily Press. The article described his efforts to establish a "realistic" medical establishment (3/10/1968). Heaton-Ward told the reporter:

> Can there be any other branch of medicine in which a consultant is expected to be responsible for 800 in-patients apart from his out-patient commitments.

The Western Daily Press (25/9/1969) also pursued Heaton-Ward's ideas about the levels of expenditure in different branches of the hospital services. The article cited figures from Morris (1969) comparing the average cost of patients' food and drink in hospital. In a mental handicap hospital the cost per person was "£1 19s. 10d. weekly compared with £2 4s 6d. in mental illness hospitals and £2 4s. 4d. in chronic hospitals during 1966 - 67".

Alderman Cyril Hebblethwaite (Chairman of the Stoke Park Management Committee) told the Western Daily Press (5/10/1969) that there were "over 300 people waiting for admission in the region". He explained to the interviewer that because there was no alternative to a place in hospital the Committee was under constant pressure to admit more people. Heaton-Ward reiterated the same point in a subsequent interview. During the interview he made an explicit reference to the lack of provision in the community. Because no other means of support were available the hospitals were compelled to take

people "not needing hospital care". He also stated that the problem would not be resolved unless the services had access to more resources:

> Dr. Alan Heaton-Ward, consultant psychiatrist at Stoke Park Hospital, Bristol, warned that there was no prospect of local authorities providing enough residential care units to prevent this unless they were given more money.
> (Evening Post, 27/10/1971)

More than ten years later Yvonne Wiley (Consultant Psychiatrist, Stoke Park) used the lack of provision in the community as a rationale for maintaining the services at Stoke Park. Although service philosophies and national policy documents (DHSS 1971, Jay Report 1979, Kings Fund Center 1981) had been signaling the expansion of community care for over a decade she did not believe that the standard of care available in the community was better than the standard of care in the hospital:

> I think that the first thing that one has to say is the community care must be at least as good as what is provided in hospital, and there is no assurance that that will necessarily be, so we have to make sure that community care is good.
> (Update: Situation Subnormal?, 1983)

Even though she told the interviewer that one third of the people living in hospitals could live in the community she was not confident that the existing community services were able to create an improvement in the quality of their lives.

In the same program Cindy Geddes (Ward Sister) said that there were a number of places available in hostels, but securing places that would enable residents to move away from the Stoke Park had been difficult:

> In the last four years that I have been here we've have had five go out into the community. The problem really is finding suitable places for them. They exist all right. As far as hostel care goes it is a case of really waiting for dead men's shoes. I have several patients at the moment who are suitable for hostel care, and have been away on holidays to the hostels, but its just waiting for the residents to pass on one way or another.
> (Update: Situation Subnormal?, 1983)

Comments made by the interviewees about the transfer of residential care from hospital to the community supported the views of Malin et al (1999, p.12) regarding the uneven pace of change. A lot of activity had occurred in the decade before the closure of the hospital. One of the interviewees recalled that when he had started working residential provision in the community was limited to four or five houses:

> I mean I can think back to when I first started and we had very few houses. A community house was like "Oh yes, that's a community house is it?" Community was such a funny little term. Everyone used to talk about the community but when you looked about - it was about four or five houses. Nowadays it's like a huge service.
> (C. Home 1, Home Manager 1)

He went on to differentiate between the transfer of accommodation and the capacity of the services to meet the needs of people living in the community:

> I think that side of things; the service will have to meet the needs of people on a much greater scale. Now I think the service is provisionally, gradually, accepting that there is a need, but whether or not there is the money to fund it - that's the problem I think. From my experience, we've been out here two years, and all the time we've been out here it's always been a question of money being in short supply. Whether it's from the DHSS, or social services, or GP fundholders. They are all very budget conscious these days. It's all "How much are we going to spend".
> (C. Home 1, Home Manager 1)

Although people had been moved from hospital into residential accommodation in the community he did not believe that they were receiving the range of services they required. The interviewee attributed the source of the "problem" to a lack of money.

Assistant Home Manager 1 worked in one of the flats managed by Home Manager 1. She noticed that the quality of residential provision had been changing while the service expanded. People were not living in the four and five bedroomed houses envisaged by Pamela Charlwood in the early 1980s[2]. The home that she worked in was a Victorian four storey building subdivided

[2] For more detail see her comments in Chapter 6, p.163.

into flats so that each floor contained a separate flat with four or five bedrooms:

> The last course I went on was the 939, and that was a little while ago, and they were talking about this being the future now. This is what services for people with learning disabilities - what seems to be the most popular. I didn't think about it until I got here. I didn't apply for it because I knew it was all right but thinking back, looking back, this is the kind of set up that they were talking about because they had to cut down costs, and they talk about group homes being very expensive. They think about expenditure all the time. They're thinking about costs and setting up places. To have a place like this where it's divided into four flats so it's cheaper to run.
> (C. Home 1, Assistant Home Manager 1)

The interviewee had observed that there was a trend towards providing residential accommodation in larger buildings; using flats instead of small, detached, group homes. Like the previous interviewee she attributed these developments to a shortage of funding. During the 1990s accommodation had been provided in flats rather than group homes because the latter were very expensive and no longer affordable. The situation she has described supports the statement by Brown (in Thompson and Mathias, 1992 p. 115) regarding the difference between the cost of ordinary housing and institutional provision. Brown stated that contrary to the views expressed in the King's fund publication "An Ordinary Life" about the comparability of costs the expenditure required to develop alternatives to traditional hospitals often exceeded the cost of the services they are replacing. Similarly Simpson (in Corker and French, 1999) has argued that the fundamental determinant of the conditions in which any concept thrives or fails is the economy.

Bill Robbins (Director, South Gloucestershire Social Services) maintained that the money being spent on rehousing people from Stoke Park was greater than the investment in other community services within the area:

> The amount of money that is required for the resettlement of people, say from Stoke Park, is five to ten times more than we are allowed, or considered reasonable for other services within our community. It is not just the Health Authorities putting money in to place people, the community care monies that we have are used to top up those and to support that as well. We are buying a very

> expensive service for a few. I make no apologies for what the community can afford to pay. I am a servant of the community, and I along with Avon Health, try and work through the most cost-effective way within the resources that we have got. But you can't square the circle of getting rid of the large, long stay, institutions and providing high quality community care within the resources that are available.
> (Close Up West, 1997)

In the same program Pamela Charlwood had stated that the average cost of a place in a "smallish", "fairly well staffed" group home would probably be around £900.00 per week. Money from benefits provided approximately £100.00 per week. She described this sum as a "useful contribution". At the same time she pointed out that it "left an awful lot still to find". In the earlier stages of the closure program she had described money from Social Security flowing "like an ever open tap". It was her belief that the tap had been shut off because the taxpayer was not prepared to make larger payments to maintain the program when the costs increased. The funding that was available made it difficult to sustain the development of small group homes so the model for residential accommodation in the community was adapted to suit the prevailing economic conditions.

The size and style of some of the more recent homes led David Hibbs (Chairman, Hanham Hall Friends) to comment on the similarities between the hospital wards that were being closed, and the homes that were opening in the community. He was not convinced that the residents moving out of Stoke Park were going to benefit from being in the community:

> ... Also the units, which are being opened now, are much bigger than the ones that have been opened in the past. They seem to be shifting whole wards in one block out into the community. I'm not happy with that because what you have got is the disadvantages of a ward with none of the advantages of being on a site where there are plenty of facilities.
> (Close Up West, 1997)

His impression of a service being moved from a hospital setting into smaller institutions in the community has been corroborated in a Department of Health study (1999a) which stated that most adults in residential care homes or

nursing homes provided in the independent sector, or run by local authorities lived in congregate residential provision rather than domestic housing.

Conclusion

Material in this chapter has examined the views of nursing staff (Registered Learning Disability Nurses and Care Assistants) on the closure of Stoke Park Hospital, and the development of community based services for people with learning disabilities. Analysis of their views has shown that the implementation of community care had changed the interviewees' perceptions of their professional role, and their impression of the range of tasks that they were engaging with. Data from the interviews has shown that community care reinforced divisions between qualified and unqualified staff working in residential services, and accentuated differences between groups of staff that had accepted organisational change and groups that had resisted it. Interviewees' accounts of the service users experience of community care have indicated that moving out of hospital had led to an improved quality of life for some residents in community homes. However, interviewees have also made reference to a positive side of hospital care that would be lost when the hospital closed.

Data from interviews with Registered Nurses (Learning Disability) has shown that they felt their role had changed as services in the community evolved. Recognition of the impact of these changes was not limited to those nurses that had moved out of the hospital into community homes. Nurses that were interviewed while they working at Stoke Park also felt that the transfer of resources between hospital and community and the gradual reduction of the services on site (i.e. the closure of wards and departments) had an impact on their role. Qualified staff commented on the number of managerial and administrative tasks that had become part of their duties. In addition to the tasks associated with moving the residents and their belongings into new homes they had also acquired responsibility for budgeting, and producing documentation relating to risk management and quality assurance. Qualified staff in community homes felt that they were more "accountable" for any

decisions that that they made regarding residents or resources because they did not have access to the advice and support that was available from other staff in the hospital. Qualified staff in the community providing supervision for hospital staff that had recently been moved detected some resistance to the process of change. They felt that some of the staff were reluctant to engage with administrative tasks, or modify routines that they had become accustomed to in the Hospital.

Data from interviews with Care Assistants corroborated views that had been expressed by the qualified staff regarding the proliferation of administrative tasks. Care Assistants perceived many of the tasks that the qualified staff engaged with as office based involving telephone calls and paper work, rather than activities that they recognised as "caring". They made a distinction between their role and the role of qualified staff based on the amount of time that Care Assistants were able to spend with the residents. Instead of engaging with paper work they were able to spend time "being with" the residents and engaging with them in everyday activities such as cleaning and shopping. Some of the qualified staff also spoke about the loss of direct contact with residents. They referred to the administrative tasks that they had to complete as tasks that consumed the time they could spend on activities with the residents.

Data from interviewees describing their experiences in the community indicated that some of the residents were experiencing problems that had been less noticeable in the Hospital. The cost of some activities meant that residents could not afford to "go out" as much as they had before. Interviewees stated that entertainment was expensive compared to the entertainment in hospital where the residents were not expected to pay admission fees. Transport was also regarded as a problem. Because activities and therapies were not available on site some of the residents were dependent on public transport or staff to provide lifts. The cost of using public transport (in addition to admission fees), or problems with lifts, had made some activities inaccessible. This had added to a sense of isolation. Residential staff had also noticed that some of the residents were not able to

sustain the range of relationships they had developed while they had been in the Hospital. This was attributed to the location of group homes (i.e. the distance between them, and the problems of getting from one to another) and a shortage of "camaraderie" in the community.

Data obtained from interviews and documentary sources indicated that a significant proportion of the resources that had been transferred between the Hospital and the community were transferred in the decade prior to the closure of Stoke Park. This reflects the availability of joint funding from Social Services and the Health Authority. During the late 1980s and the early 1990s residential provision in Bristol and the surrounding area was expanded to accommodate people moving out of Stoke Park and other long stay hospitals. Material in this chapter has shown that the scale of the buildings used to accommodate people with learning disabilities gradually increased, while the amount of money that was spent on new accommodation decreased. In the early 1980s it had been envisaged that people would move out of hospitals into ordinary houses (with four or five bedrooms). When Stoke Park closed in 1996 people were moved into large units that resembled hospital wards. The environment in similar units has been described as a "congregate setting" (DOH 1999a, p.12) because it does not resemble an ordinary house. While some professionals involved in the delivery of services for people with learning disabilities have seen this as a compromise a Director of Social Services in South Gloucestershire stated that the money spent on resettling people from Stoke Park was "five to ten" times the amount that was considered reasonable for other services in the community (Bill Robbins, Close Up West, 1997). This divergence of opinion has provided evidence of different views on priorities in welfare spending. While many of the interviewees saw moving out of the Hospital as the attainment of a basic human "right" other professionals regarded people with learning disabilities as a minority group that had secured a disproportionate share of resources that belonged to the whole community.

The concluding section of this thesis will consolidate material from the preceding chapters. Macro approaches and exploration of the micropolitics of

service delivery have contributed to the final analysis of continuity and change in the professional task.

Conclusion

Concepts, Definitions, and Characteristics That Have Been Used to Identify People with Learning Disabilities

Although people with learning disabilities, the services they use, and the staff that work in them, have frequently been described as "devalued" (Wolfensberger 1984), and "stigmatised" (Goffman 1961, 1963) the concepts and characteristics that define a "learning disability" have undergone significant changes in different historical periods. These changes have had an impact on the development of specialised services and the composition of the staff working in the services. Although each generation has acquired an inheritance from previous generations in the form of knowledge, professional expertise, buildings and the "structure" of services, neither ideas nor services have remained static. Both have been subject to revision and modification. Sometimes this has been subtle and spread over a long period of time so that the impact of change is less noticeable. On other occasions events have made a significant, or immediate impact, on the perpetrators and participants. In the case study of Stoke Park Harold Burden's decision to concentrate on mental deficiency rather than inebriacy has shown that he was conscious of a shift in attitudes towards the "problem" of mental deficiency at the beginning of the twentieth century. His participation in the Royal Commission on the Care and Control of the Feeble Minded, and the expansion of the Stoke Park site, demonstrated that he was able to exploit this awareness. Similarly the staff interviewed in 1996 were aware that the implementation of community care and the imminent closure of the hospital was going to have a profound impact on their jobs, and the lives of the people that they were working with.

Some developments have occurred because specialised knowledge pertaining to the nature and causes of learning disabilities facilitated change. Other developments occurred because of a combination of social, political, and economic factors that changed the existing social structure and altered relationships across all sectors of society. Scull's analysis (1993) of the rise of institutional solutions to control deviancy has linked the growth of "helping

professions" with the emergence of a powerful, centrally administered state between the middle of nineteenth and twentieth centuries. Polanyi (1957) has described how the forces of production, consumption, and distribution that delineated economic relationships between different parts of "market", shaped society. The emergence of a more powerful centralised and bureaucratic state, as well as the expansion of a market economy, contributed to the emergence of ideologies, norms and values that redefined both national and class interests. At the same time they altered alliances and divisions between groups. Pick (1989) has characterised these changes as ideological assimilation and expulsion. Ideas were used to establish boundaries around social groups, and to cultivate cross class allegiances that would isolate any group that was perceived as a threat. In this thesis the construction of "boundaries" related to employment, education, dependence and independence have been analysed to establish the social position of people with learning disabilities in different periods.

At the end of the nineteenth century fear about the impact of a "residuum" provided an impetus for expanding specialised services. Concern was focused on the problems that would ensue if "mental deficiency" was ignored, or the implementation of a solution was delayed. Particular concerns included the costs of providing accommodation for a growing number of "defectives", the "burden" that they would impose on future generations, and the deleterious effect of a large unemployed or unemployable group on Britain's trade and commerce. The Report produced by the Royal Commission on the Care and Control of the Feeble Minded (1908) placed greater emphasis on institutional provision. Material from the study of Stoke Park has demonstrated that the NIPRCC were established to prevent "inmates" from obtaining more expensive forms of support from the community as criminals and paupers. The case study of Stoke Park has provided an example of a large institution that was specifically designed to offer custodial care for "mental defectives".

The impetus to develop institutional solutions for the social problems associated with "madness" and "mental deficiency" indicated a movement away from community and family providing the locus of care towards voluntary, or paid

helpers, and a variety of "helping" professions. Scull's analysis of the rise of psychiatry (1993) has examined the significance of medical practitioners' claim to provide a range of cures for mental illness. Although the medical profession played a significant role in the growth of services for people with learning disabilities the profession's inability to secure a monopoly over cures, or treatment, has meant that a variety of other practitioners, helpers and service providers have been involved in developing services. This thesis has examined the involvement of Harold Burden, and the significance of contributions from other lay persons involved in the voluntary, charitable and private sectors. Material related to the development of the Colony in the early part of the twentieth century, and interviews with hospital staff at the end of the century, have examined the tasks undertaken by nurses. This material has included the work of qualified and unqualified staff. The work of unqualified nursing staff has been incorporated to demonstrate that even in an institutional setting a majority of people delivering "hands on" care were not professionals or qualified practitioners.

In the closing decades of the twentieth century the dynamic of the care market has changed. Planning and policy has been focused on decreasing the amount of institutional accommodation, and providing more support for individuals with learning disabilities and families in the community. Despite the swing away from institutional care there are many similarities that connect services at the beginning and end of the century. The implementation of community care policies in the 1980s and 1990s has continued to draw on the private, voluntary, and charitable sectors, as well as statutory providers, in a variety of public/private partnerships. Similarly the people that work in them have been drawn from a wide range of groups. They include a variety of professionals working in the health, education and social services, unqualified staff, voluntary workers and a large contingent of informal carers.

The terminology and nomenclature related to people with learning disabilities has undergone a succession of changes to avoid association with some of the stigmatising labels from the past. Some of the terminology that has developed as community care has expanded reflects the impact of the market economy on

service delivery e.g. service users, consumers, customers. They are no longer characterised as the "residuum", or a "social problem" group in the way that they were at the beginning of the century yet the transition from exclusion to inclusion has been dependent on the same centrally administered, bureaucratic apparatus that facilitated the growth of institutional care. The rhetoric of "best value" has replaced the concept of economical management espoused by Harold Burden but concern over the level of spending on welfare has continued to challenge both Labour and Conservative governments in post-war Britain. While Britain's colonial and industrial power has declined as the century progressed spending on welfare services has increased. This has meant that changes in policy have not been accompanied by large-scale investment from public funds. Emphasis has been put on containing costs, getting better value for money, or dispersing costs across different sectors. People with learning disabilities are a minority group that have been on the periphery of the decision making process, even when decisions have been made about the services they use on a daily basis. They frequently have to compete for public resources yet their collective voice does not represent the prospect of a significant number of votes for politicians at a local or national level.

Streaming and Classification

Wright (2000, p.732) has identified examples of streaming and classification involving collusion between Poor Law Union and lunacy officials in his discussion of learning disability and the Poor Law. Rudimentary classification of the "insane", "idiots" and "imbeciles" was used to identify "dangerous" and "curable" individuals in workhouses. Individuals classified as dangerous or curable were eligible for transfer to county lunatic asylums. Asylums provided confinement, supervision, and the prospect of medical intervention that would cure the afflicted individual. Most people with learning disabilities were neither dangerous nor "curable". They were retained in workhouses where they received basic food, shelter and supervision but they were unlikely to have received care involving skilled interventions that aimed to ameliorate, "treat" or "cure" their intellectual impairment. The labour of the inmates was valued because they performed tasks that would otherwise have been done by paid

staff. Similarly the managers of small private and charitable institutions utilised the labour of inmates to save money and keep the cost of maintaining their institutions low. Following the implementation of the Elementary Education Act (1870) teachers and doctors were also using their professional knowledge to develop systems for streaming in schools. They made judgements that separated "ineducable" and "educable" children, and developed "special" schools and classes for mentally defective children that were deemed to be incapable of learning in ordinary schools.

Data from the case study has shown that in the early stages of development Stoke Park was unique because it did not implement the same processes for selecting inmates that were evident in other institutions. Other institutions were less willing to offer places to people that were deemed "ineducable", or incapable of working (Gladstone 1999, p.148). Stoke Park was exceptional in its willingness to offer places for "educable" and "ineducable" children[1]. Evidence has shown that Harold Burden used the site to establish a prototypical colony that anticipated the "all-grade" institution described in the Wood Report (1929). Although the staff included a visiting Medical Officer and nurses the stimulus for developing a large, single purpose institution appears to have been an opportunity to secure a prominent position in the "care market" rather than the provision of specialised nursing and medical services. Between 1906 and 1916 the site grew rapidly. The growth of the Colony indicated that the demand for institutional accommodation was increasing. The classification of "moral defectives" had added to the number of people that were deemed to require institutional care.

Analysis of Stoke Park towards the end of the twentieth century has shown that a process analogous to streaming had been used to systematically reduce the Hospital population. Documentary evidence from the 1970s has shown that assessment criteria divided people into separate groups reflecting different levels of ability and need (NDT, 1978). It was envisaged that the least dependent group would be eligible for early discharge from hospital, while the

[1] CRIS Annual Report 1910, p226

most dependent group were likely to remain in hospital because they required intensive nursing and medical care. Data from interviews with nursing staff at Stoke Park in 1996 provided evidence that the criteria used to describe the more dependant group were comparable with descriptions of groups that were still in the hospital. This group also had attributes in common with the "back ward" group that had been identified by Jones (1975). The wards that had stayed open at Stoke Park were wards for elderly residents, people with challenging behaviour, and people with multiple impairment. Interviewees working with these groups stated that the residents that remained in the hospital had complex needs that required intensive support.

Data from interviews with staff working in community homes confirmed that they regarded the more able group as the beneficiaries of community care. They were able to take advantage of the widest range of activities and experiences that were available in the community. Although many of the residents were in accommodation with more "private" space and better décor they were not all given the same opportunity to participate in activities outside the home. Interviewees believed that moving the "less able" group into the community was a sign of progress but they found it harder to think of examples that would demonstrate that this group was participating in community life. Staff stated that residents with communication difficulties, problems with mobility, incontinence, or challenging behaviour, found it difficult to participate in recreational or occupational activities in the community. Staff in community homes had observed that the same group experienced similar problems obtaining day care packages providing access to resources that were specifically for users with learning disabilities.

Literature examining the health of people with learning disabilities has identified that they have health problems related to epilepsy, obesity, poor communication, cardiovascular and gastro-intestinal abnormalities, respiratory difficulties, impaired mobility, mental health, and Alzheimer's disease in people with Down's syndrome (DOH 1995a, p.8). Similarly groups with multiple impairment, and challenging behaviours have been described as "at risk" (DOH 1995a, p.36). Policy and planning to improve access to health services in the

twenty first century (DOH 1999b, DOH 2001) has aimed to raise awareness of learning disability issues outside specialised services (i.e. professionals in services that have not received specific preparation for work involving service users with learning disabilities). These policies are an acknowledgement that most people with learning disabilities are likely to use generic health services in the community. At the same time it suggests health practitioners that have had little or no contact with learning disability services may not be cognizant of their needs.

The Role and Function of Services

Material from the literature review in Chapter 1 has described the growth of an institutional solution to social problems that had been associated with insanity and mental deficiency. Institutions for the "mentally deficient" offered parents and other relatives an alternative to the care that had been provided by family members. Institutional care also created opportunities for professionals, commissioners, providers and purchasers of services to enter into negotiations about the role of a specialised service. Recommendations made in the Report on the Royal Commission on the Care and Control of the Feeble Minded (1908), and the Wood Report (1929), indicated that institutional "care" was seen as a way of exercising control over the inmates. Isolated buildings and constant surveillance from staff made it possible to separate them from the rest of the community. The Colony model also encouraged managers of institutions to be self-sufficient (e.g. by utilising the labour of the inmates to provide food and domestic services), and to keep their costs low by making savings through economies of scale.

Data from the case study of Stoke Park at the beginning of the century has shown that Harold Burden made use of his previous experience, and his connections with the Home Office and the Royal Commission, to develop the site at Stoke Park. Between 1909 and 1916 the amount of accommodation was increased and other resources were added (e.g. facilities for training and a hospital wing) so that by 1916 Stoke Park Colony was the "largest institution of

any devoted to the care of the Mentally Defective person"[2]. Stoke Park was different from other industrial training schools and small, private institutions because of its' size, the willingness of the managers to accept inmates with a wide range of abilities and impairments, and its' intention to provide "permanent care and control"[3].

Although the growth of the Stoke Park Colony was indicative of the expansion of institutional care it was not indicative of the extension of professional power. While the Colony paid for a "visiting medical officer" and employed "trained hospital nurses"[4] most of the staff and nurse attendants were unqualified and untrained. They were not equipped to deliver skilled interventions intended to "cure" inmates. They provided instruction, supervision and some assistance with daily activities. Most of the staff that inmates engaged with while they were carrying out routine activities had not been prepared for professional practice. Scull (1979, 1993) has maintained that the emergence of an institutional solution for lunacy led to medical domination of the psychiatric services. Although medical practitioners were involved in the development of "mental deficiency" services the labour that was required to expand the services came from different sources and not a single professional group. In addition to medical involvement there were significant contributions from lay people e.g. Burden, other lay members of the Royal Commission, and the large contingent of untrained staff that worked at Stoke Park. Similarly attempts to extend "care and control" in the community using supervision and guardianship relied on the interest (or concern) of volunteers rather than professional expertise.

Data from Chapters 6 and 7 has shown that ward staff believed the residents in the Hospital required specialised nursing care. Interviewees claimed that the group that had remained at Stoke Park needed intensive support due to the profound and complex nature of their impairment. Staff in community homes referred to their work with residents with profound and multiple impairment but they also referred to the impact of their work with a "more able" group. Staff

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[2] BOC Annual Report 1916, p.49
[3] BRO 40686/PM/8(b) p.4
[4] CRIS Annual Report 1911, p..247

from the Hospital and community homes remembered working with more able clients at Stoke Park. Nursing care for this group had been focussed on preparation for a more independent life in the community. Data from the interviews showed that Registered Nurses and Care Assistants had been affected by the growth of community care. They associated it with the closure of wards and departments, the gradual reduction of the hospital population, and changes that altered the range of tasks that they engaged with. Care Assistants believed that they had maintained close contact with the residents. They regarded their work as "hands on" caring, whereas the qualified staff engaged with office based activities and paper work. Registered Nurses observed that they were spending more time on administrative and managerial activities. While some interviewees accepted the development as part of a process of organisational change others were inclined to view it as a development that was likely to prevent them from spending time with residents or engaging with other caring activities.

Resources and Responsibilities

Analysis of data from Chapters 1 and 2 has established that economic factors exerted a powerful influence over the services that emerged at the beginning of the twentieth century. Britain's status as a leader in world trade and commitments abroad meant that effective governance of the country required careful management of the national economy. The interests of those groups involved in the production of wealth were weighed against the interests of groups that were seen as economically inactive and reliant on goods and services provided by the state or philanthropic organisations. The cost of providing specialised services was measured against the damage that "mental defectives" were likely to cause. Economic factors were also influential in determining how services for mental defectives should be delivered. This involved decisions about the extent of the state's involvement and the extent of contributions from alternative providers e.g. the family, or private and charitable agencies.

Evidence from the study of Stoke Park has shown that Harold Burden's commitment to maintaining an economical service had been a crucial factor in developing the site. His ability to provide cheap accommodation and his willingness to bring privately owned resources under "strict Governmental control"[5] had endeared him to officials at the Home Office. In addition to the evidence presented by medical practitioners and teachers the Royal Commission also considered the views of lay people that had gained practical experience from their work with mental defectives e.g. Burden, Norah Fry and Ellen Pinsent. Burden's questions revealed that he was particularly interested in the practical aspects of establishing and running institutions for the mentally defective. The information has shown that as well as guidance on the medical management of mental deficiency and the education of defectives, the Commission was interested in exploring different ideas about the management and delivery of residential services.

Analysis of correspondence relating to the NIPRCC has shown that private ownership and management of institutions, with inspection and regulation that gave central or local government opportunities to exercise "control", was appealing to Burden and the Home Office. Attempts to foster partnerships involving the state and different agencies have recurred at strategic points in the twentieth century. Partnership between the providers of institutional care, guardians, and voluntary organisations e.g. Central Association for Mental Welfare, were seen as a way of extending "control" into the community after the implementation of the Mental Deficiency Act (1913). In the 1980s the transfer of social security funds to local authorities was used to develop accommodation in private nursing and care homes so that the number of people in living in hospitals was reduced. These partnerships led to the fragmentation of services. The distribution of services between different sectors of the mixed economy has meant that responsibility for providing care has been divided between a range of professional groups and a large contingent of unqualified and informal carers. Health and social services have used unqualified staff to expand residential care in community homes. Interviews with Care Assistants

[5] Roy. Com. Feeb., VIII, p. 511

at Stoke Park Hospital have shown that even in a hospital environment the unqualified staff believed that they were the main providers of "care".

The systematic reduction of the hospital population entailed a "streaming" process that involved allocating residents to different groups reflecting their needs and abilities. Groups that remained in hospitals and other accommodation managed by the NHS required complex nursing care. Planning and implementing care for these groups was seen as the responsibility of Registered Nurses (Learning Disability). As more hospitals closed, and more people have been moved into the community, planning to provide health care for this group has become increasingly difficult. People with learning disabilities who do not have contact with specialised nurses have relied on care staff in generic services. While policy documents (e.g. DOH, 1999b) have attempted to make health practitioners aware of the needs of people with leaning disabilities the White Paper (DOH 2001, p.60.) has acknowledged that creating effective partnerships between generic and specialist practitioners is a challenge that has to be addressed in the twenty first century:

> Because mainstream health services have been slow in developing the capacity and skills to meet the needs of people with learning disabilities, some NHS specialist learning disability services have sought to provide all encompassing services on their own. As a result the wider NHS has failed to consider the needs of people with learning disabilities. This is the most important issue which the NHS need to address for people with learning disabilities.

Evandrou and Falkingham's analysis of the economics of welfare spending (1988, p.243) has indicated that informal carers are the largest group providing care in the community. They have estimated that the contribution from informal carers is more significant than the contribution from professionals and unqualified staff employed by Health and Social Services. Analysis of the factors that shape service delivery has shown that the role of learning disability nurses has been determined by the organisational context of services, and access to alternative providers of care. As services have moved into the community specialist skills are regarded as having less currency. It is

envisaged that the needs of the majority of people with learning disabilities will be met in "mainstream" services and by families in private households.

Public, Private and Professional Boundaries

The expansion of community care in the last quarter of the twentieth century has involved renegotiating the organisational roles of welfare providers and the boundaries that define the public, private, and professional domains. Clarke and Newman's analysis of the institutional reform of welfare (1997) has identified different forms of "privatisation" that are characteristic of movement between the public and private sectors. Policies initiating change in the delivery of public services have reflected reconfigurations of power in the pattern of provision and different conceptions of individual and collective responsibility. There has been a significant transfer of responsibility from health and social care services to the private realm of the family. Families and the community have been expected to take a greater role in the provision of care for people with learning disabilities. Clarke and Newman (1997, p.29) maintain that the state has not withdrawn from the organization of community care. During the 1980s and 1990s the state has extended its' influence into the private domain through the mechanisms of state assessment, evaluation and surveillance. The pattern of service delivery at the end of the twentieth century has returned to a pattern that was established prior to the expansion of institutionalised care. However, the state has continued to maintain control over the private domain through a combination of support and surveillance. This pattern of service delivery should not be attributed to the "New Right" ideologies of the 1970s and 1980s. It was the recreation, or modification of a previous pattern, rather than something new.

Clark and Newman (1997, p.28) have also described a process of "de-differentiation" that entailed the removal of some of the distinctions that separated the state and the market, and the public and private sectors. As a result of these changes public organisations were expected to behave "as if" they were commercial corporate entities. The rise of "managerialism" has meant that there was an expectation that nurse practitioners delivering

residential services would change their work based tasks and routines so that they became more "business like". Data from the interviews in Chapter 7 has shown that this expectation had created tension and divisions in the staff group. While the unqualified staff had maintained a "hands on" role some of the Registered Nurses perceived the proliferation of administrative tasks as a development that encroached on the nurse-client relationship. While some nurses were willing to engage with the tasks that had transformed their role others had offered more resistance. Johnson (1972, p.81) has characterised these tensions as differences in orientation and affiliation:

> Differences in the structural and organisational location of practitioners are, then, likely to generate divergences of orientation; there will accordingly be varying degrees of self-identification with the occupational community. We may find that the simultaneous existence of orgnisational and occupational affiliations affects the extent to which the individuals become committed to administrative needs or the problem of "client" groups. A "client" orientation is likely to be characteristic of practitioners close to the "periphery" whose relationships with their clients are more meaningful and immediate than those with their socially distant colleagues and superiors.

Comments from interviewees indicated that some nurses saw "management" as part of their professional development whereas others saw it as a responsibility that had a deleterious effect on their work with clients.

Even the nurses that resisted seemed to accept that change was inevitable and unavoidable. This may have been due to the evidence that surrounded them e.g. closed wards, plans to close the hospital, and plans for their redeployment. However nurses working in community homes had also expressed a similar sense of resignation. Some interviewees appeared to perceive themselves, and the service users, as "powerless". They believed that decisions were imposed on them by powerful people in the Trust, or by powerful figures responsible for making public policy at a national level. They felt that whether they agreed or disagreed with the decisions that were made - they could not change them. Money was identified as the most powerful agent of change. Interviewees believed that the availability or scarcity of funds was more likely to determine policy than wishes or demands from professionals, carers, or people with learning disabilities. If they wanted or desired something that required

more money they felt that it was unobtainable. Lukes (1974, p.24) has identified acceptance of the "unchangeable" nature of the existing order as an important factor in the manipulation of power:

> ...is it not the supreme and most insidious exercise of power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things, either because they can see no alternative to it, or because they see it as natural or unchangeable...

From this perspective state control over funding in both the public and private sectors means that it will continue to exert a powerful influence over the needs and desires that are articulated by practitioners, carers, and people with learning disabilities.

Reflection

In their introduction to "The Managerial State" Clarke and Newman (1997, p.XII) stated "moving forward has become more important than understanding where you have been, and practical action more important than reflection and analysis". Analysis of the interviews with nursing staff from Stoke Park has shown that many of the nurses were able to recall "where" they had come from. Remembering the past provided them with a way of reflecting on their progress and evaluating the developments in the learning disability services that they had witnessed. Many of them were able to describe and comment on the systematic reduction of the hospital population, plans to close the Hospital, and the implementation of community care policies. Interviewees used their recollection of events as a way of comparing the current range of tasks and responsibilities that occupied them with the range of tasks and responsibilities that had occupied them in the past. Some of the nursing staff thought that managerial and administrative tasks had replaced "caring". When they spoke of their work in the past they associated it with specialised nursing skills e.g. working with the "more able" group required assessment and training that would equip the residents to lead a more independent life in the community. However some interviewees had seen the accumulation of managerial and

supervisory tasks as a way of expanding and developing their professional role. They identified teaching and supervision as opportunities to monitor and improve service delivery.

This study has focused on the role of nursing staff in the learning disability services. The focus of the study reflected my background and the experience that I had gained from my work in the NHS. Although my background had provided me with some insight into the impact of continuity and change on learning disability nursing this focus was maintained by paying less attention to other groups that have provided care, education and training. The study has made reference to contributions from nursing practitioners working in primary care services (e.g. Practice Nurses, District Nurses) and social workers. Studies of both groups would provide more detail for a comprehensive analysis of the impact of community care. Examining changes in nursing practice that demonstrated acknowledgement of the needs of people using primary care services, and exploring the impact of "managerialism" on social work, would provide research that would complement the focus of this study. A study that focused on the service users' experience of the transition from hospital to the community would be another useful addition to the existing research. The experiences of the "more able" group would be particularly interesting because they were the first group to be discharged (and the group that has had the most time to adjust to life in the community). Similarly a longitudinal study of the last groups to leave would determine whether they had experienced the problems that the staff had anticipated before the move.

Appendix 1

Questions and Prompts Used in Interviews

Questions and prompts for interviewees.

What were your first impressions of services for people with learning disabilities?
To encourage the interviewee to provided more detail/description:
Was it a hospital/community home/hostel?
How many people were on the ward/in the home/hostel?
Were they adults/children/mixed?
How old were they? What was the age range?
How would you describe their abilities (e.g. "multiply disabled", "more able", "challenging behaviour")?

What was you job at the time?

What is you current job?

What are the strengths of the current services?

What are the weakness of the current services?

What do you think services are going to be like in the future?

Do you think your job is going to change in the future? How?

Do you feel optimistic or pessimistic when you think about the future?

What does the term "quality of life" mean to you?

What do people with learning disabilities need in order to enjoy a good "quality of life"?

What makes you say that?
To encourage the interviewee to provide more detail:
Is it your experience that you have gained as a Care Assistant/Nurse?

What would improve the services for people with learning disabilities?

Do some people with learning disabilities receive better services than others? Why?

Appendix 2

Flow Chart Summarising Sources of Evidence and Methodology

Literature review.

Search terms:
History of idiocy/mental deficiency/mental subnormality/learning disabilities / services.
History of welfare.
History of nursing.
Harold Burden.
Community care.

Themes:
"Continuity and Change"
"The Social Context of Services"
"The Professional Task"

Research methods:
Qualitative Data Analysis
Positivism
Phenomenology
Grounded Theory
Case Studies
Ethnography
Insider Accounts
Reflexivity

Documents

Locate public sources:
Parliamentary Papers
Bristol Records Office
Public Records Office

Locate private sources:
Newspaper cuttings
Video recordings

Preliminary categorisation

Interviews

Obtain permission to interview staff from Phoenix NHS Research Ethics Committee

Design pilot study: questions, interview techniques, ideas for sample.

Review progress: reflexive interviewing.

Negotiate access to wards at Stoke Park and community homes.
-
Insider account
-
Interviews.

Transcription
+
Preliminary categorisation

Analysis:
Middle-Order Categories
Reflection

Synthesis - Configuration of themes:
Concepts, Definitions, and Characteristics That Have Been Used to Identify People with Learning Disabilities/ Streaming and Classification/ The Role and Function of Services/Resources and Responsibilities/Stoke Park 1960 - 1990
Synecdoche – selection of interview material to be included in study

Evaluation - Conclusion:
Impact of continuity and change.
Public, Private, and Professional Boundaries.
Reflection.

Appendix 3

Application for Ethical Approval

Dr Shantha Jayewardene
Medical Director
Chair of Phoenix Research Committee

AVON & GLOUCESTERSHIRE
COLLEGE *of* HEALTH

Avon Centre
Glenside, Blackberry Hill, Stapleton, Bristol BS16 1DD
Telephone: 0117 958 5655 Facsimile: 0117 975 8498

Gloucestershire Centre
Oakes House, 55-59 London Road, Gloucester GL1 3HF
Telephone: 01452 410550 Facsimile 01452 410643

Chief Executive: Malcolm Maggs MIPD

12/10/95

Dear Dr Jayewardene

Here are the details of my research proposal assembled under the headings prescribed by the Phoenix Research Committee.

<u>The researchers.</u>
I would be the only person conducting field work. My Supervisor; Dr David Gladstone from the University of Bristol, will be advising as I progress. His expertise as a historian will be particularly useful when I start to work with the archive material. Although I intend to conduct the interviews and deliver the questionnaires on my own I would appreciate Dr Gladstone's advice on the selection and analysis of historical material. This would involve giving him access to the archive and medical library.

<u>Introduction and aims of the study.</u>
The aim of this research is to locate the current services for people with learning disabilities in a historical context. The dissertation will provide a commentary on the combined effects of continuity and change in the services. Material will be assembled around four broad themes which will provide a framework for analysing service provision in different historical periods. These themes are:

1. **Streaming and classification.** Material which relates to the ways in which services have distinguished between people with learning disabilities and the rest of the population.
2. **The role and function of services.**
3. **Concepts, definitions and characteristics attached to the users of services designed for people with learning disabilities.**
4. **The development of resources and responsibilities within the services.**

The literature search incorporates material relating to services from the late eighteenth century onwards. My intention is to make connections which span the period between the 1750s and the present day.

<u>Benefits of the study.</u>
Benefits for providers and practitioners. To contribute to the growing body of knowledge which examines the social construction

of learning disabilities. Providers of services will benefit from reading about the combined effect of a variety of factors on the services instead of regarding them from within the confines of a single academic or professional discipline. Work on the opening chapters indicates that the emergence of psychology as a scientific discipline, medical research, the role of the public and voluntary sectors, the creation of a welfare state, the concept of community care and macro-economic factors will make a significant contribution to the analysis of data.

I have chosen to use a historical perspective because I think the past exerts a powerful influence on the present and the future. The material compiled for this dissertation may help to make the connections between the past, present and future more visible.

Benefits for the College. The study makes use of an eclectic approach. It is not locked into a disciplinary structure that is dominated by nursing or sociology, although they are both valuable sources of knowledge. I believe this reflects the multidisciplinary approach that has been advocated by educationalists and service providers. Although the study draws on a number of disciplines its remains clearly focused on learning disabilities. It also my belief that research is a process which can help to focus the attention of policy makers and planners on the services and clients. All of these factors are beneficial to the College as it moves into the new faculty of Health and Social Care.

The dissertation will provide:

- **evidence of work which is built on a multidisciplinary approach,**
- **a research project that is focused on learning disabilities,**
- **a body of evidence and a source of knowledge that is based on current research.**

How the research will benefit me. I will enjoy the opportunity to meet with colleagues working in the services. If I am successful I will also gain a PhD.

<u>Methodology</u>
The proposal has four components:

- **a literature search**
- **a questionnaire** (copy enclosed)
- **interviews** (interview schedule enclosed)
- **a review of historical material.**

<u>Consent</u>
Participation will be voluntary. The interviews and questionnaire will only include those people who want to take part. Because the research is looking at the provision of services the providers of care will be the only source of information. Although I value the opinions of service users I will only be seeking the views of those people who are involved in the **delivery** of services.

I intend to use archive material which is available for public display. **It is not my intention to use material from personal files.**

Resource implications and cost.
75 % of my course fees are paid by the College. I pay the remaining 25%. The cost to the Trust will be the time spent with staff conducting interviews and completing questionnaires. I would like to gather approximately 60 completed questionnaires and conduct 20 interviews. The questionnaires take about 20 minutes to complete and the interviews between 20 and 25 minutes. I would calculate the time required using the following formula:

$$20 \text{ mins} \times 60 + 25 \text{ mins} \times 20 = \frac{1\ 700}{60} = 28.3 \text{ hours}$$

I would like to interview staff working at different levels within the organisation so that the views that are represented incorporate qualified and unqualified staff, managers etc.

I will pay any costs relating to duplication or reproduction of archive material, phone calls etc.

Confidentiality
I do not intend to use material taken from medical records, IPPs or personal files.

Areas of concern
I have some concerns about the ways in which my research may be perceived by people employed in the Trust. There is a possibility that some people may see my study as a part of the changes which have been taking place in Phoenix and will continue to take place into the new year and beyond. I am conscious of the need to assure participants that I am conducting research rather than replanning or reorganisation. I hope my position in the Learning Disabilities Team and my association with the services will assure people that I do not have anybody else's axe to grind. My strategy is to present the findings as an "insider account" of services that I am involved with instead of attempting to generate an atmosphere of spurious detachment.

My other concerns relate to the academic status of the research. I hope that my professional interests do not eclipse my academic interests. When I started this project I believed that social scientists and historians have a significant contribution to make to the development of services and the body of knowledge that professionals can draw on. My beliefs remain the same and I am convinced that this research should contribute to the pool of academic writing and discussion involving social policy and planning.

Participants who respond to the questionnaires and the interviews will remain anonymous. The **historical** material relating to Stoke Park will identify the hospital and Purdown although individuals working or living in either hospital will be anonymous.

Please do not hesitate to contact me if you require any more information.

Yours sincerely

Matthew Godsell

SOUTHMEAD MEDICAL RESEARCH ETHICS COMMITTEE

APPLICATION FOR APPROVAL OF A RESEARCH PROPOSAL

Project No	—— For Office Use Only ——	Date of submission

P A R T I

1 TITLE OF PROJECT

Identifing Priorities in Services for People with Learning Disabilities

2

RESPONSIBLE INVESTIGATORS	POST(S) HELD	HOSPITAL & DEPT
Matthew Godsell	**Registered Nurse Mental Handicap Nurse Tutor**	**Avon & Gloucestershire College of Health**
David Gladstone	**Supervisor**	**University of Bristol**

3 OBJECTIVES

1. **To evaluate priorities in services for people with learning disabilities using a historical context.**
2. **To analyse different methods of streaming and classifying people with learning disabilities.**
3. **To define the role and function of different services**
4. **To analyse the various concepts, definitions and characteristics attached to the users of services.**
5. **To trace the development of resources and responsibilities within the services.**

4 BACKGROUND

This research is being undertaken as part of a dissertation for an M.Phil/Ph.D. My Supervisor is Dr David Gladstone from the Department of Social Policy and Planning at the University of Bristol. The aim of this research is to locate the current services for people with learning disabilities in a historical context. The dissertation will provide a commentary on the combined effects of continuity and change in the services.

The literature search incorporates material relating to services from the late eighteenth century onwards. My intention is to make connections which span the period between the 1750's and the present day

5 DESIGN OF STUDY

The study has four components

1. **A literature search**
2. **A structured questionnaire (copy enclosed)**
3. **Semi-structured interviews (schedule enclosed)**
4. **A review of historical/archive material**

6 IN WHICH HOSPITAL(S) WILL BE WORK BE UNDERTAKEN?

Stoke Park Hospital and community homes/hostels within the Phoenix Trust

7 SUBJECTS

(a) How many subjects are needed?
60 questionnaires completed by different members of staff plus 20 interviews with staff

(b) How will they be selected?

By their willingness to contribute

(c) Will any 'control' subjects be used? **Not applicable**

If 'yes', please state number and how selected.

Not applicable

(d) If drugs or other potentially harmful substances are to be administered, are subjects indemnified for non-negligent injury?

If 'yes', by whom?

Not applicable

(Documentary evidence of indemnity must be submitted)

(e) Volunteers

If volunteer subjects are being used, are payments to be made to them?

Not applicable

If 'yes', state amount per subject and the source of the funding:

Not applicable

8 CONSENT

What category of consent is proposed?

Volunteers from Phoenix Staff

(Submit a copy of the consent form you propose to use, if this differs from the model consent forms attached.)

9 PROCEDURES

State procedures, if any, which would not form part of normal patient care; give number of venepunctures or other samples, indicating the volume taken where relevant:

Not applicable

10 DISCOMFORTS, RISKS

What discomfort, interference with their activities, or potential hazards may be suffered by all or any of the subjects? How do these relate to potential benefits to the individuals concerned or to patients in general?

Not applicable

11 QUESTIONNAIRES

Will a questionnaire be used for this research?

If 'yes', please submit a sample.

Yes, a sample has been enclosed

12 FUNDING

(a) How is the project to be funded?
By the researcher and Avon & Gloucestershire College of Health

(b) Have all additional drugs, pathology tests, radiological procedures etc been enumerated and costed?
Not applicable

(c) Give names of heads of departments whose resources will be used:

Ms L Williams: Director of Operations) Phoenix
Mr D Selway : Chief Executive) Trust

(d) Give details of the arrangements which have been made to fund additional drugs, tests and procedures.

Not applicable

13 INVESTIGATOR(S)

Signature of Investigator(s) ..... Date .....

Name(s) of Investigator(s) (Capitals) **MATTHEW GODSELL**

Consultant(s) supervising Project: **Not applicable**
Not applicable

Signature ..... Date .....

Name (Capitals)

14 CONSULTANTS

All consultants whose patients are involved in this research must give their permission for this work to be undertaken by signing below and indicating their specialty.

Not applicable

Name ..... Consultant in .....
(in Capitals)

Signature Date

Not applicable

Name ..... Consultant in .....
(in Capitals)

Signature **Not applicable** Date

Name ..... Consultant in .....
(in Capitals)

Signature Date

Primary Sources

Archives

Bristol Record Office: Stoke Park Hospital

Public Record Office, Kew: Board of Education, HomeOffice

Official Publications

Central Government

Reports of Commissions (in chronological order):

Report of the Departmental Committee as to the operation of the Law relating to Inebriates and their Detention in Reformatories and Retreats, (Cd. 4439, Evidence, Appendices and Index, 1908).

Royal Commission on the Care and Control of the Feeble-Minded (Cd. 4125-4221, I-VIII; Report, Cd. 4202, VIII, 1908).

Report of the Interdepartmental Committee on Mental Deficiency, 1925 – 1929 (Wood Report) Vol. 3 "The Adult Defective", (London, 1929).

Periodical and Annual Publications

Annual Report of the Board of Control to the Lord Chancellor 1916

Annual Reports of Commissioners of Reformatories and Industrial Schools 1909 – 1915

Annual Report of the Inspector of Certified Reformatories under the Inebriates Act 1899, 1906

Newspapers

Bristol Evening Post

Sunday Times

The Times

Western Daily Press

Video Recordings

Close Up West (1997) Who cares in the community? TV, BBC2, March 20

Update: Situation Subnormal? (1983) TV, BBC West

Interviews:

C. Home 1, Care Assistant 1.

C. Home 1, Care Assistant 2.

C. Home 1, Assistant Manager 1.

C. Home 1, Home Manager 1.

C. Home 2, Staff Nurse 2.

H. Ward 1, Care Assistant 1.

H. Ward 1, Care Assistant 2.

H. Ward 1, Care Assistant 3.

H. Ward 1, Staff Nurse 1.

H. Ward 1, Staff Nurse 2.

H. Ward 1, Staff Nurse 3.

H. Ward 2, Care Assistant 1.

H. Ward 2, Staff Nurse 1.

H. Ward 2, Staff Nurse 2.

H. Ward 2, Staff Nurse 3.

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